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Consumer-Directed Healthcare and
The Physician-Patient Relationship

By

Chase Floyd

Submitted in Partial Fulfillment
of the Requirements for
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Abstract

The physician-patient relationship is the most fundamental unit of medicine itself - and yet currently faces great peril, increasingly encroached upon by a number of different threats. Consumer-directed healthcare, an innovative new form of healthcare financing, empowers individuals to make their own decisions regarding their healthcare, holds providers accountable to their patients, and theoretically establishes a robust working relationship that benefits both parties. Could this be what is needed to save and strengthen the physician-patient relationship? This paper studies this question, namely the effect of consumer-directed healthcare on the physician-patient relationship, in-depth through a synthesis of existing research.

First, the importance and relevance of the physician-patient relationship are explained. The major determining factors of the relationship are then identified before context of the relationship's current state is provided. Next, the paper defines consumer-directed healthcare, specifically the two major types: Consumer-directed health plans (CDHPs) and direct primary care (DPC). The theory behind this model is given, as well as an analysis of the conceptualization of healthcare as a market. The paper then examines three distinct healthcare systems -- single-payer, the current American system, and consumer-driven healthcare -- through the lens of the previously-identified factors to assess how each one impacts the physician-patient relationship. Following that is a thorough discussion on how consumer-driven healthcare has fared (both CDHPs and DPC) since its inception and the real-world results it has produced in relation to the physician-patient relationship. The paper concludes by looking at the obstacles that stand in the way of future expansion of consumer-driven healthcare.

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Section I - The Importance of the Physician-Patient Relationship

Described as the “keystone of care”, the physician-patient relationship governs the interaction between healthcare’s two most important actors - the patient and the physician. And like all relationships, its strength is determined by the quality and quantity of interaction between the two players. If the relationship itself is the keystone, then the ‘medical interview’, or the conversation that takes place between physician and patient whenever the patient requires care, must be the glue that holds it in place, making it the “major medium of care”. One of the most landmark studies concerning the physician-patient relationship attributed three major functions to this so-called interview -- gathering information, communicating information, and establishing or maintaining the relationship -- and then linked them, asserting that the relationship determines the quality of information elicited from the patient, conveyed by the doctor, and understood by the patient. Understanding this correlation is key to understanding why the physician-patient relationship matters in the real world to real people and not just to healthcare theorists. The physician-patient relationship has important, practical implications in everyday settings of healthcare, serving as the major determinant of physician satisfaction, patient satisfaction, and patient compliance and contributing to increased quality of life and decreased practitioner burnout¹.

Why does the physician-patient relationship matter? To put it simply, it improves health. A patient’s health is largely predicated upon three things happening: Patient accessing care, doctors providing or prescribing appropriate care, and patient receiving and adhering to that care to the best of their ability. A strong physician-patient relationship has a positive effect on all three fronts. According to one study, patient satisfaction, a marker heavily influenced by the physi-

¹ Susan Dorr Goold and Mack Lipkin, “The Doctor–Patient Relationship: Challenges, Opportunities, and Strategies,” *Journal of General Internal Medicine* 14 (1999): 8.

cian-patient relationship, is a strong predictor of a patient's willingness to return for care. If a patient does not come in for care, they cannot receive the treatment they need which in turn has a negative impact on health outcomes². In addition, other research shows that individuals with a regular source of care have better access to primary care than those without; when broken down further, individuals with a regular doctor have better access than those with a regular site but no regular doctor. Access to care - that first step towards improving a patient's health - is often determined by whether said patient has a regular physician that they see (continuity of care), a factor largely entwined with the physician-patient relationship³.

The second step (the delivery of care) is largely based upon the aforementioned medical interview in which the physician collects information from the patient and uses it to appropriately recommend a course of action. The more information that the physician is able to gather, the more comprehensive the diagnosis and treatment plan as the physician takes into account family history, lifestyle, and other considerations. However, this is often hindered by patients' natural inclination to share the bare minimum or to withhold certain information they might not feel comfortable sharing. While these two may be at odds, what joins them together is the physician-patient relationship, as people in general feel more comfortable sharing with those they have a positive relationship with. One study researched this in detail, studying the effect of the physician-patient relationship on diabetic patients' willingness to share candidly with their physician. It found that the misrepresentation and/or withholding of self-care information had a statistically

² Benjamin C. Sun et al., "Determinants of Patient Satisfaction and Willingness to Return With Emergency Care," *Annals of Emergency Medicine*, May 1999, [https://www.annemergmed.com/article/S0196-0644\(00\)70003-5/fulltext](https://www.annemergmed.com/article/S0196-0644(00)70003-5/fulltext).

³ J. M. Lambrew et al., "The Effects of Having a Regular Doctor on Access to Primary Care," *Medical Care* 34, no. 2 (February 1996): 138–51, <https://doi.org/10.1097/00005650-199602000-00006>.

significant (p value = 0.05) relationship with the strength of the working relationship between patient and doctor⁴. Additional research affirms that this accumulated knowledge is put to good use, resulting in less redundant laboratory tests, more knowledgeable medication prescription, and fewer emergent referrals in favor of a ‘wait and see’ policy⁵. In addition to saving patients money from high-cost, often duplicative care, the use of accumulated knowledge in consultations allows physicians to more appropriately utilize resources - cutting straight to what their patient needs. Other factors associated with the physician-patient relationship, namely longitudinal care, have also been linked to not only an increase in accumulated knowledge but an increase in doctors' sense of responsibility towards their patients⁶. The accumulated knowledge that results from patients sharing information with their physician results in two primary outcomes: decreased resource utilization and an increased sense of responsibility, both of which indicate the development of a well-rounded diagnosis and treatment plan.

The final step towards health rests with the patient's ability and willingness to follow recommended treatment; this too is impacted by the physician-patient relationship. How a patient views the working relationship with their physician has a significant impact on how they view the value of the treatment provided to them⁷, and in turn, this perceived value influences adher-

⁴ Elizabeth A. Beverly et al., “Look Who's (Not) Talking | Diabetes Care,” *Diabetes Care* 35, no. 7 (June 2012), <https://care.diabetesjournals.org/content/35/7/1466>.

⁵ P. Hjortdahl and C. F. Borchgrevink, “Continuity of Care: Influence of General Practitioners' Knowledge about Their Patients on Use of Resources in Consultations,” *BMJ (Clinical Research Ed.)* 303, no. 6811 (November 9, 1991): 1181–84, <https://doi.org/10.1136/bmj.303.6811.1181>.

⁶ Hjortdahl and Borchgrevink.

⁷ Tatiana Koudriavtseva et al., “The Importance of Physician–Patient Relationship for Improvement of Adherence to Long-Term Therapy: Data of Survey in a Cohort of Multiple Sclerosis Patients with Mild and Moderate Disability,” *Neurological Sciences* 33, no. 3 (June 1, 2012): 575–84, <https://doi.org/10.1007/s10072-011-0776-0>.

ence to that treatment⁸. In other words, patients are more likely to adhere if they understand the importance of their treatment, and this understanding comes from a positive relationship with one's provider. If the physician-patient alliance is strong, then patients will rate their treatment more highly, presumably leading to higher adherence and better health.

It is important to point out that this chain of events only happens among patients whose only barrier to adherence is choice. However, many other barriers exist as well that prevent patients from properly adhering to recommended treatment and even from forming a physician-patient alliance in the first place⁹. The most prominent of these is cost: High out-of-pocket expenses can deter patients away from getting treatment, filling prescriptions, and coming in for routine, preventive care. Throughout this paper, special attention is given to those whose access and utilization of care is price-sensitive.

The physician-patient relationship is important because it improves health in all three phases of care: By increasing patient willingness to come in and return for care, by allowing for a more complete and holistic diagnosis, and by encouraging better adherence to treatment. These effects have manifested tangibly in the form of better health outcomes across the board. In chronically ill patients, positive improvements in health outcomes (physiological markers, behavioral markers, and subjective evaluations of overall health status) were all associated with specific aspects of the physician-patient relationship¹⁰. The physician-patient relationship is the

⁸ Koudriavtseva et al.

⁹ Lars Osterberg and Terrence Blaschke, "Adherence to Medication," *The New England Journal of Medicine* 353, no. 5 (August 4, 2005): 487–97, <https://doi.org/10.1056/NEJMra050100>.

¹⁰ S. H. Kaplan, S. Greenfield, and J. E. Ware, "Assessing the Effects of Physician-Patient Interactions on the Outcomes of Chronic Disease," *Medical Care* 27, no. 3 Suppl (March 1989): S110-127, <https://doi.org/10.1097/00005650-198903001-00010>.

hallmark of medicine, possessing real, tangible importance to health, and as such, its preservation, protection, and advancement should be of the highest priority.

As with all relationships, its strength is determined by how it is viewed by the two parties involved; in this case, the physician and the patient. If one or the other is not satisfied, the relationship suffers. While physician satisfaction and patient satisfaction may be the key drivers behind the success of the physician-patient relationship¹¹, there are a few factors beneath the surface that affect these two drivers, in turn affecting the relationship as a whole. These include time together and continuity of care.

Five-minute doctor visits are not conducive to the physician-patient relationship: Patients want to feel genuinely cared for by their physician, and physicians want to do what they became a doctor to do (that is, care for patients and practice medicine). Neither is happy when patients only have access to their doctor for a few minutes before the doctor rushes out the door to see the next patient on the schedule. Time spent in the exam room is one of the most important predictors of both patient satisfaction and physician satisfaction because the fostering of any relationship depends on time, specifically ‘value-added time’. In healthcare, value-added time refers to the times in which something is happening, such as having a procedure or talking to the provider (as opposed to waiting around). Researchers have found that patient satisfaction is strongly linked to not just the length of the visit, but how much time they spend with their physician throughout it¹². The article further suggests that physicians can enhance satisfaction not only by extending the amount of time they spend with patients in the exam room but also by being inten-

¹¹ Goold and Lipkin, “The Doctor–Patient Relationship: Challenges, Opportunities, and Strategies.”

¹² D. A. Gross et al., “Patient Satisfaction with Time Spent with Their Physician,” *The Journal of Family Practice* 47, no. 2 (August 1998): 133–37.

tional with that time. By allotting a small portion of the time to nonmedical conversation, patients feel cared for as human beings, physicians don't feel like medical robots, and this personalized care often lends itself to a stronger relationship and a more holistic view on how to improve patient health. The quantity and quality of time spent together during each encounter - value-added time - has a substantial impact upon both patient and physician satisfaction.

One literature review claims physician time is just as imperative of a resource as any other in healthcare, yet it has not been studied as such. For nonprocedural providers, it is their primary source of income. Unfortunately, increasing administrative requirements such as authorization requests and utilization review processes encroach on this important resource, taking physicians out of the exam room or tying them to their computer even when they're physically present. One of the primary sources of physician satisfaction is patient relationships, while time pressure ranks as one of the primary sources of physician dissatisfaction. Physician satisfaction has also been linked with increased quality of care as assessed by more thorough explanation of care to patients and more attention to psychosocial aspects of health. On the patient side, the review synthesized the findings of multiple studies in conclusion that longer visits allow for increased preventive care and patient involvement, and because patient participation and education are linked to higher patient satisfaction, it follows then that patient satisfaction would also be linked to more time spent between physicians and patients. This landmark review successfully correlated time spent together with increased physician satisfaction, increased patient satisfaction, and increased quality of care¹³.

¹³ David C Dugdale, Ronald Epstein, and Steven Z Pantilat, "Time and the Patient-Physician Relationship," *Journal of General Internal Medicine* 14, no. Suppl 1 (January 1999): S34-40, <https://doi.org/10.1046/j.1525-1497.1999.00263.x>.

As important as the depth of time spent together is the breadth of time together. In other words, how long have the physician and patient been in a working alliance and how many exam room encounters have they experienced during that time? If a patient only has a doctor for six months before they switch providers - or if a patient has the same physician for six years but only goes in for care every two years - the physician-patient relationship suffers. Furthermore, provider turnover can have a harmful effect on continuity, particularly in teaching hospitals and other academic healthcare settings in which residents are constantly graduating. For the physician-patient relationship to flourish, it is important that care be consistent, committed, and continuous.

Two major components of continuity exist: Relational continuity, or the history of an ongoing relationship between physician and patient, and churn, a change in insurance that causes you to lose access to your physician. Looking at relational continuity first, a literature review on patient perspectives confirmed its importance, characterizing longitudinal care and consultation experiences as the main factors that develop and maintain the physician-patient relationship¹⁴. Additional studies have found that relationship continuity is highly correlated with lower costs, fewer hospitalizations and emergency department visits¹⁵, and improved patient satisfaction. Patients having high levels of continuity with their physician benefited from a significant reduction in medical expenditures and substantially lower odds of hospitalization, to the tune of 14.1% and

¹⁴ Matthew Ridd et al., "The Patient–Doctor Relationship: A Synthesis of the Qualitative Literature on Patients' Perspectives," *British Journal of General Practice* 59, no. 561 (April 1, 2009): e116–33, <https://doi.org/10.3399/bjgp09X420248>.

¹⁵ "Continuity of Care to Optimize Chronic Disease Management in the Community Setting," *Ontario Health Technology Assessment Series* 13, no. 6 (September 1, 2013): 1–41.

16.1%, respectively¹⁶. Furthermore, relational continuity is particularly important to vulnerable populations, and this importance manifests itself in patient satisfaction. Patients who value continuity but not see their regular physician rated their visit lower than those who did¹⁷; for patients with a chronic condition, continuity is inherently linked to how they evaluate their interaction with their physician¹⁸, while also improving their receipt of preventive services¹⁹. For individuals requiring high levels of and attention to care, relational continuity is vital.

Breaks in continuity arise from churn - when a change in your insurance prevents you from seeing your physician and affects the list of physicians you can see. This can occur from changes in employer-sponsored insurance or from moving in and out of insurance altogether. Regardless, it has a disruptive effect on continuous coverage, yielding many of the opposite effects that relational continuity produces, including poor health outcomes, financial insecurity, and increased stress²⁰.

These major factors are influenced by many other factors of their own; in essence, it's a complicated system in which minor factors contribute to the major factors which in turn together set the tone of the physician-patient relationship. While time and continuity influence both pa-

¹⁶ Andrew Bazemore et al., "Higher Primary Care Physician Continuity Is Associated With Lower Costs and Hospitalizations," *The Annals of Family Medicine* 16, no. 6 (November 1, 2018): 492–97, <https://doi.org/10.1370/afm.2308>.

¹⁷ Paul A. Nutting et al., "Continuity of Primary Care: To Whom Does It Matter and When?," *Annals of Family Medicine* 1, no. 3 (September 2003): 149–55, <https://doi.org/10.1370/afm.63>.

¹⁸ Margaret M. Love, "Continuity of Care and the Physician-Patient Relationship," *The Journal of Family Practice* 49, no. 11 (November 1, 2000), <https://www.mdedge.com/familymedicine/article/60929/continuity-care-and-physician-patient-relationship>.

¹⁹ "Does Continuity of Care Improve Patient Outcomes?," *The Journal of Family Practice* 53, no. 12 (December 1, 2004), <https://www.mdedge.com/familymedicine/article/60297/does-continuity-care-improve-patient-outcomes>.

²⁰ Ingrid Brugnoli-Ensin and Jessica Mulligan, "Instability in Insurance Coverage: The Impacts of Churn in Rhode Island, 2014–2017," *Rhode Island Medical Journal*, October 2018, 4.

tient and provider, there are many other components that play into determining patient or physician satisfaction. On the patient side, satisfaction is affected by wait times, choice of provider, and value of care. Recent research indicates every aspect of the patient experience (including perceptions of the physician, quality of care, and information/instructions/treatment) correlated negatively with longer wait times, concluding that patient experience is negatively influenced by time spent waiting for provider care²¹. In a separate survey, patients who chose their physician were nearly 20% likelier to rate their satisfaction as excellent or very good; in fact, choosing one's physician was the strongest predictor of high overall satisfaction²². Furthermore, therapy adherence - an important by-product of the physician-patient relationship - was positively associated with the ability to choose your physician²³. Lastly, patient satisfaction is directly tied to perceived value of care. Like in any other market, patients seek to maximize the quality of care they receive while minimizing the cost they pay, thereby seeking 'bang for your buck'. Numer-

²¹ Bleustein C et al., "Wait Times, Patient Satisfaction Scores, and the Perception of Care.," *The American Journal of Managed Care* 20, no. 5 (May 1, 2014): 393–400.

²² Julie Schmittiel et al., "Choice of a Personal Physician and Patient Satisfaction in a Health Maintenance Organization," *JAMA* 278, no. 19 (November 19, 1997): 1596–99, <https://doi.org/10.1001/jama.1997.03550190060045>.

²³ Koudriavtseva et al., "The Importance of Physician–Patient Relationship for Improvement of Adherence to Long-Term Therapy."

ous studies have affirmed a causal relationship between medical service quality, value, patient satisfaction, and ultimately, behavioral intention to revisit with one leading to the other^{24,25,26}.

On the other side, physician satisfaction is associated with greater physician autonomy, greater control over clinical work, fewer external regulations²⁷, and less time spent on administrative and data entry tasks as compared to direct patient care²⁸. Managed care, documentation requirements, physician malpractice, consumerism, and the erosion of trust have fundamentally altered the dynamic of the physician-patient relationship - with the most significant declines in physician satisfaction related to time spent with patients, autonomy in decision-making, and the availability of leisure time²⁹. In addition, further studies have shown that physician and patient satisfaction may be linked, with patients of highly-satisfied physicians being more satisfied

²⁴ Yang-Kyun Kim et al., "A Study on Medical Services Quality and Its Influence upon Value of Care and Patient Satisfaction – Focusing upon Outpatients in a Large-Sized Hospital," *Total Quality Management & Business Excellence* 19, no. 11 (2008): 1155–71, <https://doi.org/10.1080/14783360802323594>.

²⁵ Kui-Son Choi et al., "The Relationships among Quality, Value, Satisfaction and Behavioral Intention in Health Care Provider Choice: A South Korean Study," *Journal of Business Research*, The Influence of Culture on Services, 57, no. 8 (August 1, 2004): 913–21, [https://doi.org/10.1016/S0148-2963\(02\)00293-X](https://doi.org/10.1016/S0148-2963(02)00293-X).

²⁶ Wan-I. Lee et al., "The Relationship between Consumer Orientation, Service Value, Medical Care Service Quality and Patient Satisfaction: The Case of a Medical Center in Southern Taiwan," *African Journal of Business Management*, 2010, /paper/The-relationship-between-consumer-orientation%2C-care-Lee-Chen/ef624e1ec63bb41ec5658f3403fc16057b966b4f.

²⁷ Mark W. Friedberg et al., "Factors Affecting Physician Professional Satisfaction and Their Implications for Patient Care, Health Systems, and Health Policy," *Rand Health Quarterly* 3, no. 4 (December 1, 2014), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5051918/>.

²⁸ Coleman M, Dexter D, and Nankivil N, "Factors Affecting Physician Satisfaction and Wisconsin Medical Society Strategies to Drive Change.," *WMJ : Official Publication of the State Medical Society of Wisconsin* 114, no. 4 (August 1, 2015): 135–42.

²⁹ Jennifer S Haas, "Physician Discontent: A Barometer of Change and Need for Intervention," *Journal of General Internal Medicine* 16, no. 7 (July 2001): 496–97, <https://doi.org/10.1046/j.1525-1497.2001.016007496.x>.

themselves in relation to their care³⁰. This interaction affects not only the quality of care provided but also the cost of care, as dissatisfaction on the patient side results in poor treatment adherence, dissatisfaction on the provider side is related to early retirement and increased job turnover, both of which result in unnecessary costs³¹. While many minor factors exist that are undoubtedly important, they play their role by affecting the major factors of physician and patient satisfaction which, along with time and continuity, constitute the primary drivers that influence the physician-patient relationship.

Before assessing the state of the physician-patient relationship, it is important to have context regarding the current performance of American healthcare at a systems level. The United States has an adult, non-elderly population of approximately 203 million; of this roughly 175.7 million (86.3%) have health insurance while 27.9 million (13.7%) are uninsured^{32,33}. In 2015, 55.7% of U.S. residents received their health insurance from their employer, 19.6% were on Medicaid, 16.3% were on Medicare, and 14.6% acquired private insurance directly³⁴. Roughly eight out of ten adults (84.3%) had contact with a healthcare professional in 2018, while the number of physician office visits totaled 883.7 million (2016) with 54.5% being for primary

³⁰ Jennifer S. Haas et al., "Is the Professional Satisfaction of General Internists Associated with Patient Satisfaction?," *Journal of General Internal Medicine* 15, no. 2 (February 1, 2000): 122–28, <https://doi.org/10.1046/j.1525-1497.2000.02219.x>.

³¹ Haas, "Physician Discontent: A Barometer of Change and Need for Intervention."

³² Dan Witters, "U.S. Uninsured Rate Rises to Four-Year High" (Gallup, January 23, 2019), <https://news.gallup.com/poll/246134/uninsured-rate-rises-four-year-high.aspx>.

³³ Jennifer Tolbert et al., "Key Facts about the Uninsured Population" (Kaiser Family Foundation, December 2019), <https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population/>.

³⁴ "United States : International Health Care System Profiles," in *The Commonwealth Fund*, accessed March 19, 2020, https://international.commonwealthfund.org/countries/united_states/.

care³⁵. In terms of barriers to access, there existed approximately 5,900 ‘primary care health professional shortage areas’ (2013) containing a physician to population ratio of less than 1:3,500³⁶, and a record 25% of Americans reported that they or a family member have delayed treatment for a serious medical condition in the past year (2019) due to cost³⁷. The average household with employer coverage spent \$2,200 on premiums and \$800 in out-of-pocket costs in 2016, making for an estimated 23.6 million Americans who had a high cost burden relative to income³⁸. For a typical primary care visit, the average out-of-pocket cost for an insured patient is around \$50, while uninsured patients face the full cost of \$160 (2013)³⁹. The United States leads the way in terms of lower mortality rates for various cancers as well as heart attack and ischemic stroke, but it lags behind in other key markers. Hospital admissions for preventable diseases are more frequent, there are higher rates of medical, medication, and lab errors, and more Americans use the emergency department in place of regular doctors visits. However, perhaps the most telling indicator is amenable mortality, or a measure of deaths that could have been prevented by timely and effective care. Based on an index scaled 0 to 100 in which higher scores represent low mortality

³⁵ “Ambulatory Care Use and Physician Office Visits” (National Center for Health Statistics, 2017), <https://www.cdc.gov/nchs/fastats/physician-visits.htm>.

³⁶ “Health Professional Shortage Areas (HPSAs),” Text (Bureau of Health Workforce, May 2019), <https://bhw.hrsa.gov/shortage-designation/hpsas>.

³⁷ Lydia Saad, “More Americans Delaying Medical Treatment Due to Cost” (Gallup, December 9, 2019), <https://news.gallup.com/poll/269138/americans-delaying-medical-treatment-due-cost.aspx>.

³⁸ Susan L. Hayes, Sara R. Collins, and David C. Radley, “How Much U.S. Households with Employer Insurance Spend on Premiums and Out-of-Pocket Costs: A State-by-State Look” (The Commonwealth Fund, May 2019), <https://doi.org/10.26099/s50f-rs05>.

³⁹ “Primary Care Visits Available to Most Uninsured But at a High Price” (Johns Hopkins Bloomberg School of Public Health, May 2015), <https://www.jhsph.edu/news/news-releases/2015/primary-care-visits-available-to-most-uninsured-but-at-a-high-price.html>.

rates for causes amenable to healthcare and vice versa, the United States scored last among all comparable countries⁴⁰.

Now that a point-in-time overview of healthcare in general has been provided, what about the physician-patient relationship? As one comprehensive answer to that question is impossible to determine, this section will instead look at the factors isolated earlier, using the current data on them as a lens through which to answer this question. Let's again start with those first two - time spent and continuity - that affect both physician and patient satisfaction before turning to physician and patient satisfaction individually. Contrary to what one would expect, the average length of doctors visit has actually increased over the last two decades from 17.9 minutes to 20.3 for primary care; these trends in visit duration were reciprocated for specialist visits, for different types of diagnoses, and for visits in which a procedure was performed⁴¹. However, these visits do not consist entirely of direct interaction with one's provider. One study found that during the average workday, physicians spend 27% of their time interfacing with patients directly and 49.2% of their time completing EHR and desk work; while in the exam room, these percentages change to 52.9% of clinical face time and 37% of EHR and desk work⁴². The length of time that patients and physicians are together might have slightly increased, but new responsibilities may prevent the physician from being fully present and interacting during that time.

⁴⁰ Bradley Sawyer and Daniel McDermott, "How Does the Quality of the U.S. Healthcare System Compare to Other Countries?" (Kaiser Family Foundation, March 2019), <https://www.healthsystemtracker.org/chart-collection/quality-u-s-healthcare-system-compare-countries/>.

⁴¹ Meredith K. Shaw et al., "The Duration of Office Visits in the United States, 1993 to 2010," *American Journal of Managed Care*, October 2014, <https://www.ajmc.com/journals/issue/2014/2014-vol20-n10/the-duration-of-office-visits-in-the-united-states-1993-to-2010>.

⁴² Christine Sinsky et al., "Allocation of Physician Time in Ambulatory Practice: A Time and Motion Study in 4 Specialties," *Annals of Internal Medicine* 165, no. 11 (December 6, 2016): 753, <https://doi.org/10.7326/M16-0961>.

With patients seeking primary care less often than before (due to a wide range of access and health behavior issues), continuity of care has found itself in a state of limbo. Fewer Americans than ever have a primary care provider with a drastic, disproportionate drop-off among young adults. Between 2002 and 2015, the proportion of adults with a primary care physician declined by 2%; among 30-year-olds, this percentage fell by 7%⁴³. Not only do more Americans not have a physician, but the ones that do are visiting him/her less. The U.S. Census Bureau reports that working-age adults made an average of 3.9 visits to a care provider in 2010, down from 4.8 in 2001⁴⁴. In a separate study measuring relational continuity among patients with chronic conditions, the annual number of ambulatory care visits among this population increased by nearly 40 million, yet the percentage of these visits that are primary care dropped from 57% to 46%. Granted, this survey does not employ a longitudinal analysis to estimate how many of a patient's doctor's visits were not to their regular physician, but it does serve to indicate that patients are utilizing facilities such as urgent care rather than going into their personal doctor's office⁴⁵. If patients are not seeing a physician and/or not seeing their physician regularly, then relational continuity of care cannot exist and the physician-patient relationship suffers as a result.

Many of the minor factors are a mixed bag at the moment as well. Starting with wait times, the mean wait time for new appointments in the private sector was 29.8 days in 2017, re-

⁴³ David M. Levine, Jeffrey A. Linder, and Bruce E. Landon, "Characteristics of Americans With Primary Care and Changes Over Time, 2002-2015," *JAMA Internal Medicine* 180, no. 3 (March 1, 2020): 463–66, <https://doi.org/10.1001/jamainternmed.2019.6282>.

⁴⁴ "Americans Are Visiting the Doctor Less Frequently" (US Census Bureau Public Information, October 2012), https://www.census.gov/newsroom/releases/archives/health_care_insurance/cb12-185.html.

⁴⁵ Joseph Ladapo and Dave A. Chokshi, "Continuity Of Care For Chronic Conditions: Threats, Opportunities, And Policy | Health Affairs," *Health Affairs*, November 2014, <https://www.healthaffairs.org/doi/10.1377/hblog20141118.042672/full/>.

flecting an increase (longer wait times) since the statistic was last calculated three years prior⁴⁶. For return patients seeking follow-up care, ‘third next available’ is a common measure to estimate wait times and access once you are in a practice; it can be defined as the average length of time in between a patient requesting an appointment and the practice’s third next available appointment slot. For primary care, the average wait time for third next available (i.e. follow-up visits) is 6 days⁴⁷.

Choice of provider is being increasingly threatened by the establishment of ‘narrow networks’, plans designed to create savings by limiting the pool of contracted providers to a much smaller group. While narrow networks do not constitute as big of a risk to patient choice in the group market (only 7% of firms offer them and only 2% reported eliminating a provider in the last year to cut costs), they have become increasingly prevalent in the individual market. Down from 58% three years ago, just 29% of individual plans offered any benefits or cost-sharing for out-of-network providers in 2018; a separate report found that narrow network plans made up 73% of the ACA exchanges that same year⁴⁸.

The last contributing factor to patient satisfaction was value -- what you get for what you pay. As a whole, Americans are largely satisfied with their care: 77% rate the quality of the care they receive as excellent or good while a smaller percentage (61%) are satisfied with its costs,

⁴⁶ Madeline Penn et al., “Comparison of Wait Times for New Patients Between the Private Sector and United States Department of Veterans Affairs Medical Centers,” *JAMA Network Open* 2, no. 1 (January 4, 2019): e187096–e187096, <https://doi.org/10.1001/jamanetworkopen.2018.7096>.

⁴⁷ “How Long Are Patients Waiting for an Appointment?” (Medical Group Management Association, 2017), <https://www.mgma.com/data/data-stories/how-long-are-patients-waiting-for-an-appointment>.

⁴⁸ Drew Altman, “Most People Don’t Have to Worry about Narrow Health Insurance Networks,” *Axios*, October 2018, <https://www.axios.com/narrow-health-care-networks-arent-actually-that-common-daeb99fb-45dc-43d2-895b-f99c72a2426a.html>.

overall indicating that patients are perceiving good value from their care⁴⁹. As part of a separate survey, when asked which five statements best reflect what you value most when receiving care from a provider, patients answered (in order): Affordable out-of-pocket costs, ability to schedule a timely appointment, confidence in the doctor’s expertise, convenient location, and “doctor knows/cares about me”. Interestingly enough, the only answer that remained in the top five when the same question was posed to physicians: “I know and care about the patient”⁵⁰.

By and large, the single factor currently in the largest state of peril is physician satisfaction. Over half of physicians (55.3%) describe their professional morale and the current state of the medical profession as negative with 77.8% experiencing some level of professional burnout. When asked what they find most satisfying about practicing medicine, the overwhelming majority (23.6% higher than the next most common response) answered the physician-patient relationship; however, 23.9% report being overextended and overworked, thereby limiting their ability to enjoy the thing they enjoy most about their job. When asked what they find least satisfying, loss of clinical autonomy, professional liability/malpractice, regulatory/insurance requirement, and EHRs all topped the list. 88.6% of physicians agreed that patient care in their workplace is adversely impacted by external factors such as third party authorizations⁵¹. Physician satisfaction is at an all-time low and because their satisfaction is driven largely by their interactions with pa-

⁴⁹ “In the News: Americans’ Satisfaction With Their Healthcare” (Gallup, February 2, 2018), <https://news.gallup.com/poll/226607/news-americans-satisfaction-healthcare.aspx>.

⁵⁰ “The State of Value in U.S. Health Care” (University of Utah Health, 2018), <https://uofuhealth.utah.edu/value/index.php>.

⁵¹ “2018 Survey of America’s Physicians” (The Physicians Foundation, 2018), <https://physiciansfoundation.org/research-insights/the-physicians-foundation-2018-physician-survey/>.

tients, it is seemingly reflective of the physician-patient relationship itself. Where do we go from here? How do we allow it to flourish? The answer may lie in consumer-directed healthcare.

Section II - Consumer-Directed Healthcare and its Foundation

Multiple variants of consumer-directed healthcare exist, yet they are united in a common purpose: “To harness the power of the informed, market-focused, self-motivated consumer”.

Essentially, they are dependent upon consumers, or patients, shopping around to find the health plan or provider that offers them the highest value and that best fits their personal medical needs.

Theory holds that with direct purchasing power, patients have a strong incentive to examine their options and choose their medical care carefully, spending their money wisely on what’s best for them. On the other side of it, providers and insurers are forced to compete on various metrics of value (cost, quality, etc.) in order to garner interest and attract business. However, consumer-directed healthcare rely upon enrollees and patients being informed consumers; therefore, providers and insurers must make available to them the information they need to be informed (prices, quality, etc.) in an easily accessible and understood manner⁵². With that context of the theory behind the model, let’s look now into the specifics of the different types and how they operate.

Perhaps the most common form of consumer-directed healthcare is consumer-directed health plans (CDHPs). These are high-deductible health plans (HDHPs) combined with health savings accounts (HSAs). The HDHP component functions as follows: If medical expenses fall below the deductible amount, then the patient pays out-of-pocket; if expenses are above the de-

⁵² LL.M. W. Eugene Basanta J.D., “Consumer-Driven Health Care: Legal and Policy Implications,” *Journal of Legal Medicine* 28, no. 1 (March 15, 2007): 1–10, <https://doi.org/10.1080/01947640601180232>.

ductible, then the patient pays the deductible amount and the plan covers the rest, sometimes alongside a cost that is borne by the patient (i.e. coinsurance or copays)⁵³. HDHPs are ideal for those who do not incur frequent medical costs because in exchange for the high deductible, enrollees pay significantly lower premiums; since deductibles only become relevant when enrollees actually utilize services, these individuals come out much better financially with a HDHP than with a traditional plan in which they pay more per month for care they are not accessing. Although consumers enrolled in HDHPs lack first-dollar coverage, there is an exemption for preventive care in which costs below the deductible will be covered by the plan if they are deemed preventive⁵⁴. Even then, affordability concerns still exist with HDHPs in that patients might delay needed care to avoid paying out-of-pocket, including neglecting to purchase prescription drugs⁵⁵. In addition to this, fee-for-service charges may be higher for consumers using HDHPs because there is often not a middle man negotiating provider discounts in exchange for their inclusion in a network⁵⁶. This results in higher costs being passed to the consumer at the point of purchase, many of which are paid without insurer assistance.

However, the caveat is that these out-of-pocket costs are paid for using an HSA, a tax-advantaged savings account used to pay for qualifying medical expenses. Enrollees can gain three distinct benefits by using their HSA to pay for medical care: 1) Contributions are tax-de-

⁵³ W. Eugene Basanta J.D.

⁵⁴ Committee on Child Health Financing, "High-Deductible Health Plans and the New Risks of Consumer-Driven Health Insurance Products," *Pediatrics* 119, no. 3 (March 1, 2007): 622–26, <https://doi.org/10.1542/peds.2006-3687>.

⁵⁵ W. Eugene Basanta J.D., "Consumer-Driven Health Care."

⁵⁶ Financing, "High-Deductible Health Plans and the New Risks of Consumer-Driven Health Insurance Products."

ductible, 2) Earnings and interest are tax-deferred, and 3) Withdrawals for eligible expenses are tax-free. However, since HSAs can only be used in conjunction with a HDHP, voluntary HSA enrollment largely depends on whether consumers will realize enough tax savings to make paying out of pocket affordable; if these savings are not enough, consumers may be better off enrolling in a traditional plan⁵⁷.

Over the last few years, a new model has evolved that could trigger a sea change in how we deliver healthcare: Direct primary care (DPC). Using a subscription model of payment, DPC abandons traditional fee-for-service financing in favor of patients paying their provider directly via a periodic (monthly or yearly) fee. In return, patients receive near-unlimited access with the ability to see their doctor as often as they'd like. While a variant of this - concierge care - has existed for quite a while, DPC is the first to eliminate the need for traditional insurance. With the practice coordinating the provision of primary care and the billing thereof, insurers are left responsible solely for providing wraparound plans for any care that falls outside of the practice's scope, including catastrophic care, hospitalizations, and specialist care. With a strong emphasis on preventive care, DPC promotes a continuous, ongoing, and regular physician-patient relationship. As with the other models of consumer-directed healthcare, patients are encouraged to shop around for options in their local area, comparing markers such as the cost of the periodic fee, the quality outcomes of the practice, and the inclusion of such features as screenings, scans, counseling, and telemedicine⁵⁸. However, as stated before, the ability for consumers to shop around de-

⁵⁷ Financing.

⁵⁸ Philip M. Eskew and Kathleen Klink, "Direct Primary Care: Practice Distribution and Cost Across the Nation," *The Journal of the American Board of Family Medicine* 28, no. 6 (November 1, 2015): 793–801, <https://doi.org/10.3122/jabfm.2015.06.140337>.

depends on certain information being made readily available to them, and many have called into question the viability of healthcare as a market in which participants can make rational, economic decisions. To understand the theory behind consumer-directed healthcare, it is imperative to first evaluate this claim.

To reiterate, this model is founded upon the ideals of a perfectly competitive market, namely that in markets with an unrestricted supply of services and abundant competition, prices will go down as a result of consumer influence⁵⁹. These lower prices increase consumers' purchasing power so that they can purchase more wants with their limited income⁶⁰. Perfect competition meets consumer demands, maximizes the amount suppliers provide, and produces the greatest possible output from the scarce resources available. Perfect markets yield efficiency⁶¹. Unfortunately, the market for healthcare is not perfectly competitive.

There are many reasons for this. First off, there are significant financial and legal barriers to entry for healthcare firms. This leads to monopolistic situations in which one actor (i.e. a dominant health system or insurer) is able to completely control the market and keep others out. This is dangerous because that one actor possesses the power to set prices resistant to consumer influence. Product homogeneity does not exist, as the services of one physician or the insurance plan offered by one insurer are not identical; furthermore, the health outcomes that result from consuming medical care are not entirely predictable and can vary widely. Since quality measures

⁵⁹ Paul Belien, "Healthcare Systems: A New European Model?," *PharmacoEconomics* 18, no. 1 (December 1, 2000): 85–93, <https://doi.org/10.2165/00019053-200018001-00011>.

⁶⁰ Ari Mwachofi and Assaf F. Al-Assaf, "Health Care Market Deviations from the Ideal Market," *Sultan Qaboos University Medical Journal* 11, no. 3 (August 2011): 328–37.

⁶¹ R. D. Scott, S. L. Solomon, and J. E. McGowan, "Applying Economic Principles to Health Care.," *Emerging Infectious Diseases* 7, no. 2 (2001): 282–85.

and prices are typically not made transparent by providers, and since there is massive information asymmetry between the physician and patient (physicians are trained medical professionals), patients typically end up following whatever their doctor recommends. This cultivates physician-induced demand as the physician is the one determining demand for services (by caring for the patient) and the one supplying those services. This occurrence is exacerbated in situations of extreme stress such as you or a loved one getting injured in a car accident; in these situations, rational decision-making tends to break down and consumers are unable to make a judgment. Along this thought, demand for healthcare is largely uncertain: When shopping for insurance, it is impossible to completely predict the amount of care you will need whether it's due to an accident, unexpected diagnosis, or an emergency condition. Price discrimination is common in that providers often charge different prices for the same service depending on one's insurance and income. Health is not a marketable product, and because the market for healthcare is dependent on the market for health, this non-marketability reduces the power of market forces to accurately set equilibrium prices and quantities⁶². Lastly, insurers act as third-party payers on behalf of patients which shields consumers from feeling the brunt of costs, and the market lacks a market price as there is no complete way of calculating the value of the resources used⁶³. All of these conditions, and more, are what prevents healthcare from functioning in perfect competition.

Let's use a practical example to study the implications of imperfect competition on real-world healthcare. Currently, when consumers choose a health insurance plan, whether it be the one offered by their employer or one on the ACA exchanges, they must evaluate their options

⁶² Mwachofi and Al-Assaf, "Health Care Market Deviations from the Ideal Market."

⁶³ Scott, Solomon, and McGowan, "Applying Economic Principles to Health Care."

based on a variety of complicated and hard-to-understand dimensions including cost-sharing and network providers. The difficulty of this is enhanced when considering that this information is not easily accessible nor consistently communicated, making the comparison of plans more complicated. These difficulties are exemplified by a landmark study which evidenced the majority of individuals' inability to select the most financially beneficial plan from a menu of options. Choosing a health insurance plan can be confusing and overwhelming, and this complexity and unpleasantness results in a feeling of 'inertia' for many consumers: Many never revisit their choice even as their needs and situation change, instead sticking with the plan they originally enrolled in and never becoming the savvy shopper the market requires. In response to this, the New England Journal of Medicine recommends that rather than simplifying the presentation of insurance and focusing on education at the time of enrollment, plans themselves should be made simple enough so that they are able to be easily understood. If firms offered the same set of simple products, then consumers would be able to compare their options side-by-side, allowing for increased consumer participation and increased pressure for insurers to compete on important markers such as price and quality⁶⁴.

Because of market imperfections, consumer sovereignty in healthcare has been called into question. For healthcare consumers to choose high quality healthcare products at low prices, and for healthcare firms to compete in developing and marketing these products, they must be able, motivated, and have the opportunity. On the consumer side, patients lack the necessary medical knowledge to make informed decisions (ability), lack the confidence and certainty in making these decisions and instead heed to their physician's recommendations (motivation), and

⁶⁴ George Loewenstein and Saurabh Bhargava, "The Simple Case Against Health Insurance Complexity," *NEJM Catalyst*, 2016, <https://doi.org/10.1056/CAT.16.0771>.

lack the proper information needed to compare options and make a decision (opportunity). The same goes for healthcare organizations and suppliers⁶⁵. Without these three components, consumer sovereignty - and the influence to put pressure on prices and quality - theoretically disappears, and along with it the benefits of competition in healthcare. Now armed with a basic understanding of the fundamentals of consumer-directed healthcare and its theoretical underpinnings, let's now turn to how a country's framework for healthcare affects the physician-patient relationship in principle and in practice.

Section III - The Impact of Payment Systems on the Physician-Patient Relationship

To explore this, a comparative analysis is needed to study the different types of healthcare payment systems and their impact on the physician-patient relationship. As research concerning this interaction is scarce, the four determining factors isolated earlier (time spent with physician, continuity of care, physician satisfaction, and patient satisfaction) will be used as a proxy to measure the systems' impact. While countless variations of payment systems exist in the world today, I've decided to focus our discussion on consumer-driven healthcare, how it compares to the current system in the United States today, and how it compares to its most common opponent - single-payer.

Let's work backward and start with single-payer. While a consistent definition of single-payer is lacking due to its common conflation with other universal coverage structures, it can generally be defined as the concentrated financing of healthcare from a single revenue source -

⁶⁵ M. Joseph Sirgy, Dong-Jin Lee, and Grace B. Yu, "Consumer Sovereignty in Healthcare: Fact or Fiction?," *Journal of Business Ethics* 101, no. 3 (2011): 459–74.

the government - with either complete or near-complete elimination of private insurance⁶⁶. Advocates argue that this model is advantageous in that it drastically reduces administrative costs and makes healthcare available and affordable for all individuals⁶⁷. Recently, the push towards instituting the United States' own single-payer system has been renewed, reinvigorated, and given a new face in the form of Medicare for All. The accompanying legislation has been the source of much debate both within Congress and within the populace; with its sudden relevance to the United States, I thought it to be a fitting and pertinent subject for this analysis, especially considering it is the antithesis of this paper's primary focus on consumer-driven healthcare. While quasi-single-payer exists in a multitude of countries, the most true-to-definition system is found in Canada, which will serve as the source of much of the coming data on how single-payer has affected the physician-patient relationship to date and its potential implications if enacted within the United States.

As stated before, the reduction of administrative costs is one of the main selling points for single-payer; for the purposes of this paper, I want to look at how this affects the time physicians are able to spend with their patients. When physicians face heavy administrative burden, they inevitably are forced to spend a greater portion of their day completing paperwork and other regulatory tasks, thereby cutting down on how much time they can truly engage with their patients.

Physician practices in the United States currently spend \$31 billion each year interfacing with health plans, while the administrative costs alone for hospitals consume 25.3% of their total expenditures. On a per-capita basis, practices in Canada spend 27% less per physician per year

⁶⁶ Sherry Glied, "Single Payer as a Financing Mechanism," *Journal of Health Politics, Policy and Law* 34, no. 4 (August 1, 2009): 593–615, <https://doi.org/10.1215/03616878-2009-017>.

⁶⁷ Ibid.

interacting with payer(s)⁶⁸. Another measure used to estimate the financial impact of administrative burden - known as billing and insurance-related (BIR) costs - considers specifically the variation in eligibility requirements and reimbursement procedures between payers. On the provider side, these costs could take multiple forms including obtaining prior authorizations and filing claims. A 2014 study found that \$375 billion, or 80%, of annual BIR costs in the United States constitute spending beyond what would be required in a single-payer system; this additional spending is henceforth referred to as ‘added BIR’. While the brunt of this is shouldered by the insurance industry, added BIR in physician practices still totals \$49 billion annually. The study continues on to say that BIR obligations for insurers often require additional coding by physicians beyond what is needed for clinical documentation; these requirements consume up to 2.3% of physician revenue⁶⁹. Not to mention, the mere cost of the time physicians spend interacting with health plans is estimated to be \$23-31 billion a year. Insurers aren’t the only ones investing valuable time, money and resources into BIR, it’s having a tangible impact on physicians as well⁷⁰.

But how does these financial costs translate into actual time lost with patients? Clearly, if there’s a cost to the time that physicians spend doing administrative work, it means that physicians could have spent that time doing something else more productive (i.e. practicing medicine),

⁶⁸ Dante Morra et al., “US Physician Practices Versus Canadians: Spending Nearly Four Times As Much Money Interacting With Payers,” *Health Affairs* 30, no. 8 (August 1, 2011): 1443–50, <https://doi.org/10.1377/hlthaff.2010.0893>.

⁶⁹ Aliya Jiwani et al., “Billing and Insurance-Related Administrative Costs in United States’ Health Care: Synthesis of Micro-Costing Evidence,” *BMC Health Services Research* 14, no. 1 (November 13, 2014): 556, <https://doi.org/10.1186/s12913-014-0556-7>.

⁷⁰ Lawrence P. Casalino et al., “What Does It Cost Physician Practices To Interact With Health Insurance Plans?,” *Health Affairs* 28, no. Supplement 1 (January 1, 2009): w533–43, <https://doi.org/10.1377/hlthaff.28.4.w533>.

but what is the full scope of this cause-and-effect relationship between administrative burden and physicians' time? To circle back to our previous studies, the total time spent by physicians in Canada interacting with payer(s) is 2.2 hours/week. In the US, that number is 3.4 hours/week. Most of this difference results from US doctors spending an hour per week obtaining prior authorizations, a monotonous and time-consuming task that would be absent if the United States were to adopt a single-payer system⁷¹. Furthermore, the average BIR processing time is 13 minutes for a primary care visit, 32 for an ED visit, and 73 for a general inpatient stay⁷². Granted, physician time is not the only measure and/or component of administrative burden. The hiring of additional staff is often necessitated to handle administrative work, while other healthcare personnel experience changes in their schedule as well due to these types of responsibilities; however, these effects are not pertinent to this paper's focus on the physician-patient relationship. While physicians in the US interact with many different health plans that offer different policies, different formularies, and different requirements for prior authorizations, billing, and claims (all of which drastically increase the amount of time physicians spend on BIR), physicians in Canada and other single-payer countries deal with the same one payer which offers the same one product. This fundamental consolidation of payers allows physicians to spend less time navigating administrative complexity and more time seeing patients.

However, administrative burden is not the only important variable to consider when assessing whether physicians are spending enough time with their patients. Reducing that burden may clear one obstacle but another still remains: The need to maximize the number of patients a

⁷¹ Morra et al., "US Physician Practices Versus Canadians."

⁷² Jiwani et al., "Billing and Insurance-Related Administrative Costs in United States' Health Care."

physician sees in a day. Elementary math would tell us that the more you split something, the less each participant gets; it's the same way with doctors' schedules. The more appointments on a doctor's schedule, the less time they are able to spend with each patient. Therefore, even if physicians aren't having to spend hours filling out paperwork and managing red tape, there's no guarantee that increase in time is going towards strengthening the physician-patient relationship, especially if physicians' schedules are so overbooked that they're obligated to run from exam room to exam room.

To show the effects of heavy patient caseloads, let's take a look at the United Kingdom. It is important to note that the United Kingdom practices socialized, single-payer medicine -- different from the system found in Canada and different from the one advocated for in the United States. However, I think it can be an important example of what can happen when physicians see too high a number of patients per clinical day. According to a survey of over 1,500 UK general practitioners (GPs), full-time family doctors see an average of 41 patients a day. One in ten see 60 patients or more a day. For reference, the safe limit is often quoted to be 30⁷³. While this obviously hinders the physician-patient relationship by cutting down on the time physicians can spend with patients, the repercussions have extended to affect other determinants of the relationship as well. Accused of "hemorrhaging family doctors", the United Kingdom faces a severe provider shortage as job dissatisfaction continues to rise. A quarter of all British GPs now wish to quit and more than $\frac{2}{3}$ describe their professional morale as fairly low or very low⁷⁴. Perhaps

⁷³ "Revealed: 11-Hour Days, 41 Daily Contacts and Half of GPs Working Unsafe Levels," *Pulse*, May 2019, <http://www.pulsetoday.co.uk/news/revealed-11-hour-days-41-daily-contacts-and-half-of-gps-working-unsafe-levels/20038661.article>.

⁷⁴ Zosia Kmiotowicz, "Quarter of GPs Want to Quit, BMA Survey Shows," *BMJ: British Medical Journal* 323, no. 7318 (October 20, 2001): 887.

more foreboding for the future, this feeling seems to be felt more by the younger generations of doctors - with 45.5% of the ones who quit between 2009-2014 under the age of 50. It has been stated that organizational changes to the National Health Service (or NHS, the governmental body of the United Kingdom's healthcare system) have led to an increase in administrative tasks, a lack of time spent with patients, diminished job satisfaction and professional autonomy, and a workload that has fundamentally changed the doctor-patient relationship by compromising doctors' ability to perform patient-centered care⁷⁵. All of these problems are likely related in part to widespread NHS underfunding. Government funding has not kept pace with the country's increasing demand for healthcare⁷⁶, creating a cycle in which doctors have to see more patients, which leads to more doctors leaving the workforce, thereby exacerbating this provider shortage. When physicians are forced to accommodate high numbers of patients, the physician-patient relationship suffers as a result.

Looking away from the United Kingdom, what causes physicians in fee-for-service countries like Canada and the United States to have to see so many patients? The root issue is often underpayment. As physicians are reimbursed less, they make up for it by either seeing more patients or by shifting their payer mix to better-paying patients - both of which carry significant consequences for the physician-patient relationship. Having to see more patients limits the amount of time physicians can spend with each patient, while a shift in payer mix is associated with other concerns. If practices elect to see more of a certain group of patients (ex. The ones

⁷⁵ Natasha Doran et al., "Lost to the NHS: A Mixed Methods Study of Why GPs Leave Practice Early in England," *British Journal of General Practice* 66, no. 643 (February 2016), <https://bjgp.org/content/66/643/e128>.

⁷⁶ "NHS Five Year Forward View" (National Health Service, 2014).

with good insurance), then inevitably the patients who are not seen face severe access issues, preventing them from having any kind of a relationship with their primary care physician. Privately-insured patients in practices or hospitals that do not adjust their payer mix may fall victim to ‘cost sharing’, healthcare’s version of price discrimination in which providers charge insured patients more to compensate for the loss incurred from providing care to the uninsured⁷⁷.

Underpayment for physician services is already a problem in the United States, as Medicaid and Medicare reimburse providers at significantly lower rates than the private sector⁷⁸. Medicaid reimbursement is by far the lowest, on average paying 72% of what Medicare pays⁷⁹. Furthermore, hospitals only end up receiving 87 cents for every dollar they spent on Medicaid and Medicare patients⁸⁰. Because of this, providers often discriminate which patients to accept based on their insurer. Only half of physicians accept new Medicaid patients, compared to more than 70% for privately-insured or Medicare patients. Inadequate reimbursement is the most frequently-cited reason for limiting Medicaid patients (84%); however, 70% also cite concerns about paperwork and 65% cite concerns about billing delays. One study found that the length of

⁷⁷ Austin B Frakt, “How Much Do Hospitals Cost Shift? A Review of the Evidence,” *The Milbank Quarterly* 89, no. 1 (March 2011): 90–130, <https://doi.org/10.1111/j.1468-0009.2011.00621.x>.

⁷⁸ Trudy Millard Krause, Maria Ukhanova, and Frances Lee Revere, “Private Carriers’ Physician Payment Rates Compared With Medicare and Medicaid,” *The Journal of Texas Medicine* 112, no. 6 (2016), <https://www.texmed.org/June16Journal/>.

⁷⁹ Kayla Holgash and Martha Heberlein, “Physician Acceptance Of New Medicaid Patients: What Matters And What Doesn’t,” *Health Affairs*, April 2019, <https://www.healthaffairs.org/doi/10.1377/hblog20190401.678690/full/>.

⁸⁰ “Underpayment by Medicare and Medicaid Fact Sheet” (American Hospital Association, January 2019), <https://www.aha.org/factsheet/2019-01-02-underpayment-medicare-and-medicaid-fact-sheet-january-2019>.

time for reimbursement adversely affects physician participation in Medicaid⁸¹. Inefficiencies within existing government healthcare have discouraged many physicians from participating; if single-payer were to be enacted within the United States, these inefficiencies are unlikely to go away.

Currently, the United States' mixed public-private system allows many providers to make up for underpayment from government healthcare by seeing more private patients; the underpayment from Medicaid and Medicare 'balances out' with the high reimbursement rates from private insurers. However, single-payer proposals in the United States like Medicare-for-All threaten to take away this windfall by eliminating private insurance. This would turn underpayment into a serious problem as government reimbursement would be the only form of income for physicians. Not to mention, under single-payer systems offering universal coverage, everyone gains access to healthcare, which in turn reduces access as providers face a large influx of new patients. Based on data from other countries and experiences with existing government-run healthcare, the introduction of a single-payer system could force providers into accommodating a significantly higher volume of patients -- which would subsequently limit the amount of time physicians are able to spend with each one.

With reviews on single-payer being mixed, let's turn our attention to how the current system in the United States has fared. Already, some of the statistics mentioned previously throughout our discussion on single-payer have shed some light on the merits of a mixed, multi-payer system, but I'd like to tune in our analysis to study specifically at how the convoluted

⁸¹ Peter J. Cunningham and Ann S. O'Malley, "Do Reimbursement Delays Discourage Medicaid Participation By Physicians?," *Health Affairs* 27, no. Supplement 1 (January 1, 2008): w17–28, <https://doi.org/10.1377/hlthaff.28.1.w17>.

American system has impacted the state of the physician-patient relationship. First, let's look at the framework of such a system and its implications before turning to how the relationship has evolved since implementation of the Patient Protection and Affordable Care Act.

Let's start with a history of managed care. Kickstarted in the early 1970s, managed care essentially describes a number of arrangements in which the cost of medical care is 'managed' by controlling which providers patients can go to receive care. Behind the scenes, this is done through an arrangement between insurers and providers stipulating that insurers will send their enrollees to specific physicians in exchange for a cut in prices by the physician. This often results in lower premiums but less choice for the enrollee. However, even more problematic for the physician-patient relationship is the underlying structure of managed care. Regardless of whether the physician is receiving a flat reimbursement per patient (capitated) or is paid via a discounted fee-for-service agreement (non-capitated), the incentive is still for physicians to limit the amount of time they spend with each patient⁸².

Continuity also serves as a major determinant of the physician-patient relationship, and unfortunately, the current system is not privy to protecting this quintessential component of care. Nearly half of Americans receive health insurance from their employer⁸³, and many of these plans are characterized by their provider network, a list of practices that enrollees can go to for care. But what happens when you as a patient are forced off your network and your old physician is no longer a part of your new network? This can happen for two reasons: One being you change jobs and subsequently lose access to your old plan, and the other being that your employ-

⁸² Dugdale, Epstein, and Pantilat, "Time and the Patient-Physician Relationship."

⁸³ "Health Insurance Coverage of the Total Population" (Kaiser Family Foundation, 2018), <https://www.kff.org/other/state-indicator/total-population/>.

er changes insurance plans for financial or other reasons. This churn isn't an uncommon occurrence either, as evidenced by a study in Michigan. Only 72% of those who had employer-sponsored insurance in 2014 were continuously enrolled in the same plan over the following year. Furthermore, churn affects those fluctuating between Medicaid, subsidized private insurance, employment-based coverage, and a loss in eligibility for all three. That same study reported 30% of all Medicaid recipients in Michigan experienced at least a stint of losing insurance over that same period⁸⁴. Churn disrupts continuity of care by shifting enrollees to a new network of participating providers, and provision of health insurance based on your place of work has contributed to this failure to maintain continuous coverage.

While both managed care and provider networks have been staples of the American system for quite some time, what has been the effect of some of the recent implementations in healthcare, namely the Affordable Care Act (ACA)? Perhaps the most noticeable impact of the 2010 legislation, known colloquially as Obamacare, has been its effect on the number of insurers in the market. Since its enactment, three of the nation's largest insurers (Aetna, UnitedHealth, and Humana) have all withdrawn to some significant extent from the ACA exchanges. All three attribute their decision to losing money due to the high cost of providing care to a large and expensive risk pool; other factors likely also played a role, including uncertainties over Medicaid expansion, cost-sharing subsidies, and the future of the legislation itself⁸⁵. Whenever large insurers like these drop out of the exchanges, their enrollees (those who enrolled through the ex-

⁸⁴ Elizabeth Austic et al., "INSURANCE CHURNING" (University of Michigan, November 2016), <https://poverty.umich.edu/research-publications/policy-briefs/insurance-churning/>.

⁸⁵ Rachel Fehr, Rabah Kamal, and Cynthia Cox, "Insurer Participation on ACA Marketplaces, 2014-2020" (Kaiser Family Foundation, November 2019), <https://www.kff.org/private-insurance/issue-brief/insurer-participation-on-aca-marketplaces-2014-2020/>.

changes) are forced to find a new insurer and therefore a new network, adversely affecting continuity of care⁸⁶. The ACA has had other impacts on churn as well, specifically for low-income individuals. One estimate asserts that the 29.4 million people who will change coverage systems as a result of the ACA make up 31% of all persons who will either receive Medicaid or exchange subsidies during any given year⁸⁷. To this same effect, other research asserts that the current focus on increasing access has come at the cost of relational continuity (predicated upon informal conversations and interpersonal trust) as this increase in access has made it more difficult for patients to see the same doctor⁸⁸.

Predating the Affordable Care Act by just a year, the American Recovery and Reinvestment Act has also had significant, underlying implications on the physician-patient relationship. In it, then-President Obama issued a mandate to healthcare providers to adopt a government-approved EHR system or risk not qualifying for full reimbursement from Medicaid and Medicare⁸⁹. Obviously not wanting to lose their bottom line, practices and providers adopted EHRs, and the response from the majority of physicians has been overwhelmingly negative. Nearly half (49%) of office-based primary care providers report that using an EHR detracts from their clinical effectiveness, with 69% agreeing that using an EHR takes valuable time away from patients and

⁸⁶ Alison Kodjak, "Aetna Joins Other Major Insurers In Pulling Back From Obamacare," *National Public Radio*, August 2016, <https://www.npr.org/sections/health-shots/2016/08/16/490207169/aetna-joins-other-major-insurers-in-pulling-back-from-obamacare>.

⁸⁷ Matthew Buettgens, Austin Nichols, and Stan Dorn, "Churning under the ACA and State Policy Options for Mitigation," June 2012, 12.

⁸⁸ Bruce Guthrie et al., "Continuity of Care Matters," *BMJ* 337 (August 7, 2008), <https://doi.org/10.1136/bmj.a867>.

⁸⁹ Paul Christopher Webster, "Electronic Health Records a 'Strong Priority' for US Government," *CMAJ: Canadian Medical Association Journal* 182, no. 8 (May 18, 2010): E315–16, <https://doi.org/10.1503/cmaj.109-3218>.

74% saying that using an EHR has increased the total number of hours worked on a daily basis. On average, patients receive 31 minutes of care - 19 of which are spent in the EHR - making 62% of the time being devoted to each patient instead being devoted to data storage and billing/revenue (the primary purposes of EHRs, according to primary care providers). Because of this, 7 out of 10 physicians agree that EHRs greatly contribute to physician burnout while 54% say that using an EHR detracts from their professional satisfaction⁹⁰. Combine this with the effects of the Affordable Care Act, which has been accused of raising system-wide administrative costs for private insurance (factoring in necessary government expenditures)⁹¹, and recent government legislation has increased the amount of administrative burden and regulatory work felt by physicians, thereby adversely affecting the amount of time they are able to spend with their patients, their professional level of job satisfaction, and the physician-patient relationship.

Now that we've analyzed one end of the spectrum as well as the middle ground, let's finally turn our attention to the other end: A healthcare system based on consumer choice. In this system, individuals would be empowered with the tools they need to acquire the health insurance plan that best fits their needs, whether that be a traditional plan with a broad network, a managed care plan, a short-term plan, a high-deductible plan with a health savings account, or a direct primary care subscription. A system that offers a wide variety of robust options like these incentivizes consumers to shop around and get the coverage that's right for them. If you're a healthy young adult, you might not want to be locked into paying a high premium every month for

⁹⁰ "How Doctors Feel About Electronic Health Records: National Physician Poll by The Harris Poll" (Stanford Medicine, 2018).

⁹¹ Robert Book, "The ACA Increased, Rather Than Decreased, Administrative Costs Of Health Insurance," *Forbes*, February 2017, <https://www.forbes.com/sites/theapothecary/2017/02/01/the-aca-increased-rather-than-decreased-administrative-costs-of-health-insurance/>.

healthcare you're not even utilizing, so you might instead opt for a catastrophic care plan. Or if you're searching for a plan to fit your family's diverse healthcare needs, a traditional or managed care plan might be more better-suited. Rather than a one-size-fits-all approach, a system predicated upon consumer choice forces the market to offer a slate of different options that work for you.

While such a system may seem conducive to producing high levels of patient satisfaction as individuals are able to shop around until they get what they want, it also increases the number of payers that doctors must interact with. As evidenced by the research on the two previously-discussed healthcare systems (single-payer and mixed public-private), anytime physicians are required to learn multiple billing procedures and protocols, administrative costs often rise as a result. According to a source cited earlier, as much as 80% of BIR costs are attributed to the presence of multiple payers⁹². In addition, private plans in particular often have much higher administrative costs than their public counterparts. A 2017 study from the *Annals of Internal Medicine* found that private insurance spends 12.2% of all health care expenditures on administrative costs. This same statistic measures 2% for traditional Medicare plans compared to 12.3% for Medicare Advantage (Medicare's privately-administered alternative) and 10.6% for Medicaid (most Medicaid recipients are now on private managed care plans)⁹³. As shown before, administrative burden seems to foreshadow deterioration of the physician-patient relationship.

⁹² Jiwani et al., "Billing and Insurance-Related Administrative Costs in United States' Health Care."

⁹³ David U. Himmelstein, Terry Campbell, and Steffie Woolhandler, "Health Care Administrative Costs in the United States and Canada, 2017," *Annals of Internal Medicine* 172, no. 2 (January 21, 2020): 134, <https://doi.org/10.7326/M19-2818>.

However, international case studies seem to indicate that it is possible to have low administrative costs without sacrificing consumer choice. Switzerland, for example, has managed to achieve universal coverage of its populace (with 99.5% of citizens having health insurance) through an entirely privatized system. Under the Swiss system, purchasing health insurance is an individual responsibility, as there are no government-run programs or employer-based coverage. Instead, low-income persons have their insurance subsidized by the government based on income. Because there exists approximately 100 different private insurance companies each with their own unique plans, insurers must compete on price, quality, and the type of plan they offer⁹⁴. Despite this, the Swiss have some of the lowest administrative expenditures among developed countries, coming in at 4.3% of total health expenditures⁹⁵. Some of the success stories from our counterparts around the globe suggest that low administrative burden and a strong listing of options for one's health insurance are not mutually exclusive.

Despite nearly 100 different options to choose from, nearly half (42%) of Swiss citizens elected to enroll in a high-deductible plan⁹⁶. In Singapore, another country widely praised for its consumer-based system, citizens are forced to pay into a health savings account that is used for most routine care, while a separate high-deductible plan pays for catastrophic care⁹⁷. Granted,

⁹⁴ Avik Roy, "Why Switzerland Has the World's Best Health Care System," *Forbes*, April 2011, <https://www.forbes.com/sites/theapothecary/2011/04/29/why-switzerland-has-the-worlds-best-health-care-system/#2a309b6a7d74>.

⁹⁵ Michael Mueller, Luc Hagenars, and David Morgan, "Administrative Spending in OECD Health Care Systems: Where Is the Fat and Can It Be Trimmed? | READ Online," in *Tackling Wasteful Spending on Health*, 2017, 229–64, https://read.oecd-ilibrary.org/social-issues-migration-health/tackling-wasteful-spending-on-health/administrative-spending-in-oecd-health-care-systems-where-is-the-fat-and-can-it-be-trimmed_9789264266414-9-en#page2.

⁹⁶ Avik Roy, "Why Switzerland Has the World's Best Health Care System."

⁹⁷ D. A. Reisman, "MEDISAVE AND MEDISHIELD IN SINGAPORE: GETTING THE BALANCE RIGHT," *Savings and Development* 30, no. 2 (2006): 189–215.

these two are relatively small, wealthy countries, making private plans and health savings much more approachable; in contrast, the United States has a large, economically diverse population that has proven incapable of putting money into savings. Comparisons between any nation and the United States is difficult for this reason: The United States is just so unique. Nevertheless, this does not change the fact that in private, consumer choice-centered systems around the world, consumer-driven healthcare is a major component of how many citizens finance their medical care. For the remainder of this comparative discussion, let's look at this model - consumer-driven healthcare - and how it influences the physician-patient relationship.

Starting with this determinant of quality time, DPC physicians are often able to invest much more time and attention to each of their patients. The reason behind this is simple: DPC practices are typically much smaller than the average traditional practice. For example, Qliance (a collection of local DPC practices based in Seattle, Washington) practitioners carry an average panel of approximately 800 patients - a half to a third of the size of a typical patient panel⁹⁸. By caring for a smaller number of patients, DPC providers do not have to pack more and more appointments into a day to meet their bottom-line⁹⁹. The average Qliance practitioner sees about ten patients, handles three to ten phone calls, and interacts with one to five patients via email in a typical day. This high level of communication and interaction translates into a stronger and more substantive relationship that goes far beyond the 'business' partnership that we have come to expect from our trips to the doctor's office. In addition, because of these smaller patient panels,

⁹⁸ "A Direct Primary Care Medical Home: The Qliance Experience | Health Affairs," accessed March 6, 2020, <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2010.0047>.

⁹⁹ Charlotte Huff, "Direct Primary Care: Concierge Care For The Masses," *Health Affairs* 34, no. 12 (December 1, 2015): 2016–19, <https://doi.org/10.1377/hlthaff.2015.1281>.

Qliance and other DPC practices are able to offer same-day primary care appointments in addition to around-the-clock access to their physician, thereby eliminating wait times, improving access, and enhancing the patient experience¹⁰⁰.

On the other side of the relationship, it has been said that DPC has the potential to attract physicians into primary care by offering an income comparable to that of a traditional practice. DPC has been associated with many different markers of physician satisfaction, including increased autonomy (no prior authorizations), increased opportunity to care directly for patients, and a competitive income. In 2008, the average family practice medical revenue per physician was \$621,338; divided by the average active panel size, the annual revenue generated per patient was approximately \$276. Using \$60 as the baseline for an average DPC monthly fee, the annual gross revenue per patient in a DPC practice is \$720 - 2.6 times the family practice average. DPC can generate the same annual revenue per provider as a traditional practice with just 863 patients, or 38 percent of an average panel. Apart from the expenses all practices face (taxes, supplies, etc.), this discrepancy is due to DPC's significantly lower cost of overhead that is the result of eliminating insurance reimbursement, automating monthly billing processes, and reducing administrative staff to the minimum needed to manage the smaller panel¹⁰¹. One study found that simply by eliminating interactions with insurers, DPC practices can reduce overhead by more than 40%. This clears up significant time for physicians to spend with patients as opposed to completing paperwork for billing. Research claims that physicians realize three major benefits from the implementation of DPC: 1) Increased availability, 2) More time to spend with patients,

¹⁰⁰ "A Direct Primary Care Medical Home: The Qliance Experience | Health Affairs."

¹⁰¹ Huff, "Direct Primary Care."

and 3) Lower overhead. All three of these contribute to physicians interacting with their patients more often, more consistently, and for longer periods of time¹⁰².

On the patient side, consumer-driven healthcare positively affects the physician-patient relationship by incentivizing consumers to choose a provider that is the best fit for them. The principle through which patient choice theoretically brings about competition amongst providers is one of ‘voting with your feet’: Patients looking to maximize the value of their healthcare will compare the prices and quality of different providers before ultimately choosing the one that suits their preferences and needs¹⁰³. Patient involvement in this process keeps both parties engaged and enhances the working relationship. It is important to bring up the market failures discussed earlier and how they are potentially disruptive, particularly in regards to the unavailability of price and quality information.

DPC may be able to combat some of these issues as it simplifies and streamlines the enrollment process. Rather than comparing complicated premiums, deductibles, and copays, individuals looking to enroll in DPC only have to compare monthly membership fees. Unlike traditional insurance which can feel like you’re in an arranged marriage with your physician, DPC is based on mutual selection by both patient and physician. Because of this, the physician must ensure they are providing care at a high value or the patient will simply withdraw and enroll somewhere else since those barriers for switching are reduced under DPC. For example, if a physician tries to maximize their time by limiting contact with their patients (perhaps by unnecessarily re-

¹⁰² Eskew and Klink, “Direct Primary Care.”

¹⁰³ Aafke Victoor et al., “Determinants of Patient Choice of Healthcare Providers: A Scoping Review | BMC Health Services Research | Full Text,” *BMC Health Services Research* 12, no. 272 (August 2012), <https://bmchealthservres.biomedcentral.com/articles/10.1186/1472-6963-12-272>.

ferring out), then patients will likely feel as if they are not getting adequate value from their monthly fee and will subsequently end the relationship.

Not only does perception of value result in higher patient satisfaction, but shopping around and consumer choice also promote continuity of care, as DPC is based on patients choosing the best physician for them and then seeing that physician every time they access primary care¹⁰⁴. However, the opposite effect may occur for low-income individuals - unable to afford the monthly subscription fee or other out-of-pocket costs - as they instead lose access to their physician. The next section will address real world implications like this one as part of a greater discussion on how consumer-driven healthcare has fared since implementation.

SECTION IV: Evaluating the Success of Consumer-Directed Healthcare

Now that the theory behind how consumer-driven healthcare is *supposed* to benefit the physician-patient relationship has been studied, let's see if they've actually done that, starting with the data on CDHPs.

According to the National Center for Health Statistics at the Centers for Disease Control and Prevention, 45.8% of privately-insured persons under the age of 65 are enrolled in a HDHP; of this 45.8%, 20.4% have an HSA in addition to their HDHP (2018). Overall enrollment in HDHPs has increased significantly over the last decade - from 25.3% in 2010 to 45.8% in 2018 - but the most remarkable and noteworthy change has been the drastic increase in the latter category. The percentage of those engaged in true consumer-directed healthcare (i.e. Those with a

¹⁰⁴ Philip Eskew, "In Defense of Direct Primary Care," *Family Practice Management* 23, no. 5 (October 2016): 12–14.

HDHP and a HSA) has nearly tripled since 2010 (7.7%); this growth has continued into recent years as well, with a 2.2% increase from 2017-2018¹⁰⁵.

Looking specifically at the employment-based market of private insurance, among adults aged 18-64, the percentage of those enrolled in a traditional plan decreased from 85.1% in 2007 to 56.6% in 2017, while the percentage enrolled in an HDHP with an HSA increased from 4.2% to 18.9% over that same period. Employment-based coverage is an important sector to study, as it's the source of insurance for the majority (60%) of adults and has experienced faster growth in regards to HDHP enrollment than those who directly purchased coverage¹⁰⁶. In the individual market, HDHPs are the dominant plan, representing over four-fifths of plans offered on the Affordable Care Act exchanges¹⁰⁷. Approximately 55% of HSA-eligible plan enrollees reported HSA contributions to the IRS in 2004, with the average deduction for these contributions equaling around \$2,100. Roughly two-thirds of employers offering these types of plans contributed to their employees' HSAs¹⁰⁸.

CDHPs have been effective in reducing both overall healthcare spending as well as individual spending. While little research exists on the long-term fiscal impact of CDHPs, reduced spending has been observed for individuals in firms offering CDHPs in all three years post-offer.

¹⁰⁵ Robin A. Cohen, Emily P. Terlizzi, and Michael E. Martinez, "Health Insurance Coverage: Early Release of Estimates From the National Health Interview Survey, 2018" (National Center for Health Statistics, 2018), <https://doi.org/10.1037/e565212009-001>.

¹⁰⁶ Robin A. Cohen and Emily P. Zammitti, "High-Deductible Health Plan Enrollment Among Adults Aged 18–64 With Employment-Based Insurance Coverage" (National Center for Health Statistics, 2018).

¹⁰⁷ Rachel Dolan, "High-Deductible Health Plans," *Health Affairs*, 2016, <https://www.healthaffairs.org/doi/10.1377/hpb20160204.950878/full/>.

¹⁰⁸ United States Government Accountability Office, "CONSUMER-DIRECTED HEALTH PLANS: Early Enrollee Experiences with Health Savings Accounts and Eligible Health Plans," August 2006, <https://www.gao.gov/assets/260/251066.pdf>.

This reduction has been attributed to decreased spending on outpatient care and pharmaceuticals, with no evidence that emergency department or inpatient care spending has increased either¹⁰⁹. Another study concluded that switching to a CDHP reduced annual outpatient spending by over \$200¹¹⁰.

Perhaps the biggest question mark for CDHPs is whether greater cost exposure has led to more effective care utilization, a sense of greater value, and increased consumer satisfaction. In other words, have CDHPs incentivized consumers to ‘shop around’ for their care? While CDHPs have succeeded in driving down medical spending for patients, research seems to indicate that this reduction is due to reduced utilization of services¹¹¹ rather than consistent price shopping. While one study did suggest that enrollment in HDHPs has a positive effect on price shopping for laboratory tests (as demonstrated by a 12.8% reduction in price), there was no such evidence for physician office visits. The study’s authors attribute this discrepancy to several reasons, including variance in physician quality, reluctance to change physicians, lesser price dispersion for physician office visits, and perhaps most importantly, the lack of standardized and systematized information on physician prices and quality. However, patients in HDHPs may still experience lower costs, not because of price shopping, but because of physicians further lowering their ne-

¹⁰⁹ Amelia M. Haviland et al., “Do ‘Consumer-Directed’ Health Plans Bend: The Cost Curve Over Time?,” *National Bureau of Economic Research*, no. 21031 (July 2015).

¹¹⁰ Rachel O. Reid, Brendan Rabideau, and Neeraj Sood, “Impact of Consumer-Directed Health Plans on Low-Value Healthcare,” *The American Journal of Managed Care* 23, no. 12 (December 2017): 741–48.

¹¹¹ United States Government Accountability Office, “CONSUMER-DIRECTED HEALTH PLANS: Health Status, Spending, and Utilization of Enrollees in Plans Based on Health Reimbursement Arrangements,” July 2010, <https://www.gao.gov/new.items/d10616.pdf>.

gotiated prices to offset the higher price sensitivity of HDHP patients and to retain their market share¹¹².

A separate analysis reached a similar conclusion. Using surveys from a large employer and comparing the data across those enrolled in a high-deductible CDHP, a low-deductible CDHP, and a PPO, one body of work studied employees' information use and cost-saving utilization decisions. Less than half of employees reported using cost information, and an even smaller minority reported comparing the quality of providers. Of these minorities, enrollees in the low-deductible CDHP were the most likely to access and use information in making their healthcare decisions, although PPO enrollees were as likely to compare prescription drug prices. Furthermore, only a small percentage of employees not using cost and quality information in 2003 started doing so in 2004 (the year CDHPs originated). This indicates that the implementation of CDHPs did not have a significant effect on the willingness of enrollees to utilize healthcare information. However, those employees enrolled in CDHPs were statistically more likely to have initiated cost information use in 2004, showing that those wanting to use information did so strongest shortly after enrollment¹¹³. Various focus groups echoed these general findings, with few HSA-eligible enrollees reporting that they researched the cost of care before obtaining it, despite many reports of researching the cost of prescription drugs. Participant-listed reasons for their low levels of information use included: General discomfort with asking their physician

¹¹² Xinke Zhang et al., "Does Enrollment in High-Deductible Health Plans Encourage Price Shopping?," *Health Services Research* 53, no. Suppl Suppl 1 (August 2018): 2718–34, <https://doi.org/10.1111/1475-6773.12784>.

¹¹³ Anna Dixon, Jessica Greene, and Judith Hibbard, "Do Consumer-Directed Health Plans Drive Change In Enrollees' Health Care Behavior?," *Health Affairs* 27, no. 4 (July 1, 2008): 1120–31, <https://doi.org/10.1377/hlthaff.27.4.1120>.

about prices, physicians not always knowing the cost of their services (usually handled by a billing office), and limited reporting of key quality measures such as volume and outcomes¹¹⁴.

The article also showed that high-deductible employees were significantly more likely to engage in risky cost-saving behavior, such as not going to the doctor when they think they should, and only slightly more likely to make appropriate cost-saving decisions, such as opting for a less-expensive diagnostic test. This imbalance in cost-consciousness among CDHP enrollees manifests itself in fewer physician visits and less frequent pharmacy use but higher hospital admission rates. These findings showing HDHP enrollees not using available information even to make the simplest cost-saving decisions suggest that enrollees will be unwilling to comprehensively shop between providers and support the prior source's conclusion that CDHPs do not result in price shopping for office visits¹¹⁵. However, a separate survey paints a different picture, showing HDHP enrollees to be more involved than traditional enrollees. More than one-third (39%) of HDHP enrollees attempted to utilize cost information prior to receiving care, compared to 25% of traditional plan enrollees, and they were also more likely to engage in cost-conscious behaviors, including checking whether their care would be covered (55% vs. 41%), checking the quality rating of a provider (41% vs. 33%), and conversing with their doctor about alternative treatment options and costs (37% vs. 31%)¹¹⁶. While 'price shopping' may be a bit of

¹¹⁴ United States Government Accountability Office, "CONSUMER-DIRECTED HEALTH PLANS: Early Enrollee Experiences with Health Savings Accounts and Eligible Health Plans."

¹¹⁵ Dixon, Greene, and Hibbard, "Do Consumer-Directed Health Plans Drive Change In Enrollees' Health Care Behavior?"

¹¹⁶ Paul Fronstin and Edna Dretzka, "Consumer Engagement in Health Care: Findings From the 2018 EBRI/Greenwald & Associates Consumer Engagement in Health Care Survey" (Employee Benefits Research Institution, 2018), <https://www.ebri.org/health/publications/issue-briefs/content/consumer-engagement-in-health-care-findings-from-the-2018-ebri-greenwald-associates-consumer-engagement-in-health-care-survey>.

a stretch, recent data does seem to corroborate that CDHP consumers do access information and use it to make rational decisions (to differing extents), thereby validating the need for further research to evaluate the claim that consumer-driven healthcare yields higher value for consumers.

Zooming out and setting aside this determinant of value, what about general enrollee satisfaction within CDHPs? Unfortunately, that doesn't bode well for the model either. Current levels of enrollee satisfaction are significantly lower for CDHPs (46%) and standalone HDHPs (37%) than traditional plans (61%). On the other side, very few traditional plan enrollees were dissatisfied with their plan, as opposed to 16% of CDHP and 22% of HDHP enrollees. Satisfaction markers are fairly consistent across plan type for quality of care received, ability to schedule an appointment, and choice of physicians, with HDHP satisfaction lagging slightly behind both CDHP and traditional. It is worth pointing out that traditional plans and CDHPs cover similar medical care services, including preventive care, and use similar provider networks¹¹⁷. While one would think that enrollees in a consumer-driven plan would have increased choice of physician, the continued reliance on provider networks says otherwise. Interestingly, among HDHP enrollees, satisfaction with ease of getting a doctor appointment fell from 63 percent in 2013 to 54 percent in 2014. Ignoring this outlier, it seems then that the primary differentiator is out-of-pocket costs, with 48% of traditional enrollees, 26% of CDHP enrollees, and 19% of HDHP enrollees satisfied. Overall, these rankings are consistent with the percentage of enrollees likely to stay with their current health plan if given the chance to change (traditional - 65%, CDHP - 50%,

¹¹⁷ United States Government Accountability Office, "CONSUMER-DIRECTED HEALTH PLANS: Early Enrollee Experiences with Health Savings Accounts and Eligible Health Plans."

HDHP - 41%)¹¹⁸. Seeing as continuity of health plan is a major determinant of continuity of care, it is worth noting that regardless of plan type, neither patient satisfaction nor consumer engagement increases when participants stay in their health plan for a long time¹¹⁹. Perhaps the silver lining for CDHP advocates is that overall satisfaction rates have been trending upward for CDHP and downward for traditional plans; if these trends were to continue, maybe one day, CDHP enrollees will find themselves more satisfied, but today, that is not the case¹²⁰.

The relationship between CDHPs and primary and preventive care is also worth studying. CDHPs are designed to exempt the cost of preventive care from the HDHP's deductible to deter the negative impact of cost-sharing. While at first, this may seem to increase the use of preventive care amongst CDHP enrollees, many are unaware of this nuance and instead choose not to go at all rather than risk paying out-of-pocket. In addition, with CDHP enrollees paying the full price for office visits (before reaching the deductible), and with these prices often being much higher under CDHPs than under other plans, CDHPs might have the adverse effect of decreasing the overall number of office visits, which could also result in less preventive screening and fewer referrals for preventive services¹²¹. In one systematic review, HDHPs were found to have an as-

¹¹⁸ Paul Fronstin and Anne Elmlinger, "Satisfaction With Health Coverage and Care: Findings from the 2014 EBRI/Greenwald & Associates Consumer Engagement in Health Care Survey," 36, no. 7 (2015): 24.

¹¹⁹ Paul Fronstin, "The Impact of Length of Time Enrolled in a Health Plan on Consumer Engagement and Health Plan Satisfaction: Findings from the 2017 Consumer Engagement in Healthcare Survey" (Employee Benefits Research Institution, 2018), <https://www.ssrn.com/abstract=3245198>.

¹²⁰ Fronstin and Elmlinger, "Satisfaction With Health Coverage and Care: Findings from the 2014 EBRI/Greenwald & Associates Consumer Engagement in Health Care Survey,."

¹²¹ Matthew D. Eisenberg et al., "The Long Term Effects of 'Consumer-Directed' Health Plans on Preventive Care Use," *Journal of Health Economics* 55 (September 2017): 61–75, <https://doi.org/10.1016/j.jhealeco.2017.06.008>.

sociative effect with significant reductions in both preventive care and office visits¹²². The physician-patient relationship suffers when patients aren't coming in regularly to their physician. Another study showed reduced rates for a number of primary and preventive services -- doctor visits, hypertension screenings, flu vaccinations, mammograms -- for HDHP enrollees without a health savings account¹²³; the lack of a designated savings account set apart for healthcare expenses likely exacerbates this negative effect. In a separate study examining true CDHPs, researchers found little evidence connecting CDHPs with decreased cancer screenings up to three years post-offer¹²⁴. In fact, further research has shown that - after care has been sought - CDHP enrollees fare much better than traditional enrollees in a number of quality indicators. Preventive exam use is 14.8% higher, and CDHP enrollees are approximately 10% more likely to follow and comply with treatment¹²⁵. Referencing the first section, patient adherence has consistently been a telltale sign for a robust physician-patient relationship, with improvement in quality of care being one of its most important after-effects.

However, these statistics could be skewed due to one very important confounding factor - unrelated discrepancies in participant health. One report found that HRA enrollees generally spent less and used fewer health services than the PPO group *prior* to switching into the HRA,

¹²² Rajender Agarwal, Olena Mazurenko, and Nir Menachemi, "High-Deductible Health Plans Reduce Health Care Cost And Utilization, Including Use Of Needed Preventive Services," *Health Affairs* 36, no. 10 (October 1, 2017): 1762–68, <https://doi.org/10.1377/hlthaff.2017.0610>.

¹²³ Anuradha Jetty et al., "Privately Insured Adults in HDHP with Higher Deductibles Reduce Rates of Primary Care and Preventive Services," *Translational Behavioral Medicine* 8, no. 3 (23 2018): 375–85, <https://doi.org/10.1093/tbm/ibx076>.

¹²⁴ Eisenberg et al., "The Long Term Effects of 'Consumer-Directed' Health Plans on Preventive Care Use."

¹²⁵ Melinda Beeuwkes Buntin et al., "Consumer-Directed Health Care: Early Evidence About Effects On Cost And Quality," *Health Affairs* 25, no. Supplement 1 (January 1, 2006): W516–30, <https://doi.org/10.1377/hlthaff.25.w516>.

suggesting the employees who opted for the HRA were already a healthier group¹²⁶. Therefore, surface-level comparisons between the two groups (in terms of economic savings and reductions in care) must ensure that any cost-consciousness associated with CDHPs is not conflated with selection bias into these types of plans based on health. The existence of this bias does make sense, as CDHPs by design are better suited for healthier individuals: CDHP enrollees incur higher annual costs than traditional enrollees for extensive use of care but for low to moderate use, costs are lower¹²⁷. If HSA-eligible plans only yield financial benefits for low to moderate use of care, then it is logical that those who utilize this amount of care would be the ones to place into them.

This is not the only inherent difference between the two groups though; not only are CDHP enrollees in better health, but they are also typically higher income and more educated¹²⁸. In 2004, 51% of tax filers who reported contributing to an HSA that year had an adjusted gross income exceeding \$75,000, compared to 18% of all tax filers under 65 years of age¹²⁹. In the employment-based market, income and education had slight downward effects on enrollment in traditional plans, but their most substantive effect by far was on enrollment in HDHPs with HSAs. CDHP enrollment increased from 7.9% among those with incomes below 138% of the federal poverty level to 22% among those with incomes greater than 400%; enrollment also in-

¹²⁶ United States Government Accountability Office, "CONSUMER-DIRECTED HEALTH PLANS: Health Status, Spending, and Utilization of Enrollees in Plans Based on Health Reimbursement Arrangements."

¹²⁷ United States Government Accountability Office, "CONSUMER-DIRECTED HEALTH PLANS: Early Enrollee Experiences with Health Savings Accounts and Eligible Health Plans."

¹²⁸ Fronstin and Dretzka, "Consumer Engagement in Health Care: Findings From the 2018 EBRI/Greenwald & Associates Consumer Engagement in Health Care Survey."

¹²⁹ United States Government Accountability Office, "CONSUMER-DIRECTED HEALTH PLANS: Early Enrollee Experiences with Health Savings Accounts and Eligible Health Plans."

creased from 10.7% among those with less than a high school education to 23.9% among those with a bachelor's degree or higher¹³⁰. Clearly, socioeconomic factors play a role in determining who has CDHPs and who doesn't.

Unfortunately, not everyone has a choice in their healthcare plan while others may be led astray, leading to individuals being enrolled in plans that are not the best fit for them. When this happens, these three distributing factors (health, income, education) not only affect initial enrollment but also impact care utilization and access. Perhaps the most evident example of this is foregone care due to cost. When patients forego care, the physician-patient relationship suffers - as a result of a combination of different factors discussed in Section I. A relationship can't thrive if one party isn't seeing the other. Unfortunately, a plethora of data seems to reveal that the framework of CDHPs is more conducive to enrollees avoiding or delaying care due to cost¹³¹. In one survey, one-third of HDHP enrollees reported delaying care as opposed to 18% of traditional plan enrollees¹³². Furthermore, this effect is disproportionately felt by low income individuals or individuals with chronic conditions. Of CDHP enrollees, 40% of those with health problems and 48% of those with an annual income of below \$50,000 have delayed or avoided getting care due to cost, as compared to 21% and 26% of those enrolled in comprehensive plans¹³³. This is a ma-

¹³⁰ Cohen and Zammitti, "High-Deductible Health Plan Enrollment Among Adults Aged 18–64 With Employment-Based Insurance Coverage."

¹³¹ Buntin et al., "Consumer-Directed Health Care."

¹³² Fronstin and Dretzka, "Consumer Engagement in Health Care: Findings From the 2018 EBRI/Greenwald & Associates Consumer Engagement in Health Care Survey."

¹³³ Paul Fronstin and Sara R. Collins, "Early Experience With High-Deductible and Consumer-Driven Health Plans: Findings From the EBRI/ Commonwealth Fund Consumerism in Health Care Survey," Issue Brief (Employee Benefits Research Institution, December 2005).

major component of why general satisfaction and re-enrollment are high among CDHP enrollees yet they would not broadly recommend these plans for all consumers¹³⁴.

While costs are a given in healthcare, the reason why foregone care is more common with CDHP enrollees - and the reason this occurrence is more profound in vulnerable populations - is because of the high out-of-pocket burden associated with HDHPs that traditional insurance does not have. New enrollees within HDHPs experienced a mean marginal increase of \$285 in out-of-pocket costs within their first year of enrollment, relative to traditional plan enrollees. For the low-income and chronic conditions subgroups, these out-of-pocket costs rose to \$306 and \$387. Defining financial burden as spending 3% or more of household income on out-of-pocket spending, the study found that the probability of experiencing financial burden increased 4.3% across the full HDHP sample, 8% for the chronic conditions subgroup, and 12.3% for the low-income subgroup¹³⁵.

A separate report examined financial burden through the lens of employer-based coverage versus privately-purchased insurance. It found that for HDHP enrollees that received insurance from their employer, they were more likely than those in traditional employer-sponsored plans to forgo or delay care and more likely to face problems paying their medical bills; for privately-insured adults who directly purchased coverage, there were no significant differences in financial barriers between HDHPs and traditional plans. In addition, the report found that incomes in the employment-based market between those with traditional plans and those with HDHPs were similar, while the distribution was different for those who directly purchased their plans, with those

¹³⁴ United States Government Accountability Office, "CONSUMER-DIRECTED HEALTH PLANS: Early Enrollee Experiences with Health Savings Accounts and Eligible Health Plans."

¹³⁵ Zhang et al., "Does Enrollment in High-Deductible Health Plans Encourage Price Shopping?"

who purchased traditional plans generally earning a lower income than those who purchased a HDHP¹³⁶. Putting these two together, the report's findings make sense: HDHP individuals in the employer-based market have similar incomes yet face financial barriers, while HDHP individuals in the direct purchase market have higher incomes and an absence of barriers. HDHPs require higher out-of-pocket spending than traditional plans which a higher income is able to support, allowing direct purchase individuals to not experience financial burden while those who receive employer-based coverage resort to risky cost-saving measures, such as foregoing care.

What about direct primary care? As an even newer model, how has it been faring? As of 2015, researchers had identified a total of 141 DPC practices spanning 39 states. The overwhelming majority of practices (93.2%) had less than four providers at the time. 82% had price information available online and 53% self-described using the exact phrase “direct primary care”. Averaging membership fees across this 53% (75 practices), the mean monthly cost to patients was \$77.38¹³⁷. It does seem that the number of practices nationwide has increased substantially since 2015, growing to over 400 practices in 47 states¹³⁸.

While most are too small or too young to be useful for research purposes, two practices have already made a name for themselves as the leaders in DPC: Access Health Care and Qliance. One article offers great insight into the inner workings of DPC by presenting Qliance as

¹³⁶ Robin A. Cohen and Emily P. Zammitti, “High-Deductible Health Plans and Financial Barriers to Medical Care: Early Release of Estimates From the National Health Interview Survey, 2016” (National Center for Health Statistics, 2016), <https://doi.org/10.1037/e565212009-001>.

¹³⁷ Philip M. Eskew and Kathleen Klink, “Direct Primary Care: Practice Distribution and Cost Across the Nation,” *The Journal of the American Board of Family Medicine* 28, no. 6 (November 1, 2015): 793–801, <https://doi.org/10.3122/jabfm.2015.06.140337>.

¹³⁸ Philip Eskew, “In Defense of Direct Primary Care,” *Family Practice Management* 23, no. 5 (October 2016): 12–14.

a case study. After launching in 2007, Qliance now reaches 25,000 patients in the Seattle area through five primary clinics¹³⁹. The organization offers same-day primary care at a monthly age-adjusted rate of \$44-\$84 independent of health status and pre-existing conditions. In addition to routine check-ups and appointments, Qliance also provides commonly-needed ancillary services - such as digital x-rays, electrocardiograms, and on-site lab tests - at no additional charge. Many of Qliance's enrollees have their DPC membership bundled with a low-premium, wraparound plan to cover non-primary care, claiming that individuals are able to save 35% or more on comprehensive care¹⁴⁰. At Access Health Care, an unpublished study conducted by two North Carolina universities showed that Access' patients spent 85% less out-of-pocket than other patients receiving the same level and amount of care at a traditional practice. Separately, Qliance reports that its patients' healthcare costs are nearly 20% lower than those of patients being cared for elsewhere. The company's analysis attributes this reduction in costs to fewer hospitalizations and emergency department visits¹⁴¹. Aside from the obvious financial benefits, this likely contributes to higher levels of patient satisfaction as they avoid dreaded (and expensive) hospital visits.

For many of the smaller DPC practices, membership relies on individual enrollment, but for larger groups such as Qliance, they receive the majority of their patients from contracts with large employers in which the employer (ex. Expedia) agrees to pay the practice's membership fee as an employee benefit. However, Qliance still has a substantial direct purchase base of its own,

¹³⁹ Charlotte Huff, "Direct Primary Care: Concierge Care For The Masses," *Health Affairs* 34, no. 12 (December 1, 2015): 2016–19, <https://doi.org/10.1377/hlthaff.2015.1281>.

¹⁴⁰ "A Direct Primary Care Medical Home: The Qliance Experience | Health Affairs," accessed March 6, 2020, <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2010.0047>.

¹⁴¹ Huff, "Direct Primary Care."

with nearly a fifth (5,000) signing up and purchasing their own plan via the insurance exchanges¹⁴².

Based on internal data from both Qliance and Access Health Care, patients at these practices receive an average of 35 minutes with their physician per visit and average 4 visits each year, compared to an average of 8 minutes per visit and 2 visits each year under the traditional system¹⁴³. Even ignoring the additional touch points between physicians and patients that occur over email and phone, the amount of time physicians spend with the patients is significantly higher in a DPC practice than in a traditional setting. One calculation estimates that DPC physicians see their patients for an average of 140 minutes per year compared to 33 minutes by other primary care providers¹⁴⁴. As stated repeatedly before, increased time spent together is the primary determinant of a strong physician-patient relationship, as it has a positive effect on both the physician and patient side.

For the two practices large enough and established enough to have collected quality outcomes data, the data indicates that this measure of care seems to favor the model as well. Internal reports show that Qliance patients have experienced a greater than 50% reduction in emergency department visits, specialist visits, advanced radiologic testing, and surgical procedures than traditional practices; in fact, the only measure of utilization that went up for Qliance patients is the number of primary care visits¹⁴⁵. Presumably, DPC offers a lot of value to its enrollees:

¹⁴² Eskew and Klink, "Direct Primary Care."

¹⁴³ Eskew and Klink.

¹⁴⁴ Eskew, "In Defense of Direct Primary Care."

¹⁴⁵ Eskew and Klink, "Direct Primary Care."

Low costs, high quality, better preventive care, less secondary care, more time with their physician, and unlimited access. All of these are associated with high levels of patient satisfaction. This satisfaction is evidenced in the data as well, with monthly renewal rates at Qliance averaging 99%, on top of a patient base that is constantly growing by 5%-20% every month¹⁴⁶. In Washington - the state with the most experience with DPC - patient reports have been nothing but positive, with no patient complaints had been filed against any of the 33 practices - serving 11,504 patients - since the model was first introduced in the state in 2007¹⁴⁷. These accounts serve as a testament to patients' perception of quality, value, and overall satisfaction under a DPC system. While obviously individual value measures may differ between practices, the model itself incorporates this, as patients are able to take these differences into consideration as they compare practices before ultimately choosing the one that's best for them.

Satisfaction isn't just high on the patient end, but on the physician side as well. Since its first clinic opened, there has been no turnover among the thirteen providers within Qliance, highlighting the high levels of physician satisfaction. This is likely due in large part to the fact that Qliance does not bill externally for anything it provides, thereby reducing physician frustration with third-party paperwork¹⁴⁸. Furthermore, interest in DPC among physicians is growing. As of 2014, only 2% of physicians reported working in direct primary care, but an additional 7% were contemplating whether to make the switch. The same AAFP survey in 2015 revealed that 10% were now working in a direct primary care practice or had immediate plans to start while

¹⁴⁶ "A Direct Primary Care Medical Home: The Qliance Experience | Health Affairs."

¹⁴⁷ Eskew, "In Defense of Direct Primary Care."

¹⁴⁸ "A Direct Primary Care Medical Home: The Qliance Experience | Health Affairs."

43% more were actively considering it. Wanda Filer, the American Academy of Family Physicians (AAFP) president, stated that by scaling back the number of patients doctors are responsible for, DPC has the potential to reduce burnout, prevent early retirement, and encourage more medical students to pursue primary care. The ability to prescribe care as needed using one's own clinical judgment likely also carries some appeal, as physicians no longer have to receive preauthorization from insurers but rather can make the decision themselves¹⁴⁹.

As with CDHPs, concerns arise with DPC over whether low-income individuals and families will be able to afford it. Although the combination of a DPC practice's membership fee and the premium for a catastrophic care plan has been shown to be cheaper (and reduce costs in the long-run) than traditional, comprehensive insurance, the idea of paying 'twice' still serves as a major deterrent to many. And as mentioned before, when access issues lead to patients not coming in to see their doctor, the physician-patient relationship suffers. Using Qliance as a case study once again, we can observe how the DPC model has adjusted itself to ensure that vulnerable populations are not excluded from accessing their healthcare.

For starters, patients with chronic conditions often benefit from having DPC, as it allows for unlimited access and promotes close relationships with one's provider for a population that needs it the most. For low-income individuals, Qliance typically offers free or discounted care for Medicaid and Medicare patients at the practice level¹⁵⁰. However, Qliance also reached an agreement with the state of Washington's Medicaid program in which Qliance enrolled 20,000 patients via a Medicaid managed care contract; in return, Medicaid simply paid the patients'

¹⁴⁹ Huff, "Direct Primary Care."

¹⁵⁰ "A Direct Primary Care Medical Home: The Qliance Experience | Health Affairs."

membership fees as part of a shared savings program¹⁵¹. This shows that at all levels, different workarounds exist to ensure access for vulnerable populations. Low-income individuals don't have to be excluded from receiving care through DPC; it may just take an adjustment to how our country currently finances care for these specific groups of individuals.

So what's the next step for DPC? Clearly, there is still much work to be done for this still nascent form of healthcare delivery. One poll conducted just two years ago (2018) found that nearly $\frac{3}{4}$ (74%) of the 1,435 healthcare leaders surveyed were not yet aware of the DPC model¹⁵², and another source used extensively throughout this paper began with the disclaimer that a "thorough literature search" revealed a "paucity of data" surrounding DPC¹⁵³. Unfortunately, many obstacles stand in the way of further expansion. Likely the largest is the uncertainty over how to properly classify the model. In other words, is it insurance and should it be regulated as such? As of 2016, 17 states had passed laws pertaining to DPC, most of which served to except DPC from the traditional definition of insurance¹⁵⁴. In states that have not passed such a law, this lack of clarification still stands in the way of future expansion. One piece of federal legislation seeks to address another prominent issue hindering DPC: Allowing patients to use their HSAs to pay the monthly fee for DPC. Currently, one cannot use HSA funds to finance insurance, but if legislation like the Primary Care Enhancement Act were to pass, this obstacle would be removed. While many seemingly-small nuances still stand in the way, DPC does have

¹⁵¹ Eskew and Klink, "Direct Primary Care."

¹⁵² "Advantages and Limitations of the Direct Primary Care Model" (Medical Group Management Association, May 2018), <https://www.mgma.com/data/data-stories/advantages-and-limitations-of-the-direct-primary-c>.

¹⁵³ Eskew and Klink, "Direct Primary Care."

¹⁵⁴ Eskew, "In Defense of Direct Primary Care."

broad support from the nation's centerpiece of healthcare legislation, the Affordable Care Act (ACA). The ACA allows for bundled DPC and wraparound coverage packages to be sold on state exchanges so that they may be compared 'apples to apples' alongside traditional insurance plans¹⁵⁵. This was a good first step towards increased awareness of the model and enhanced consumer control over their healthcare, but further work is needed to ensure that the forward progress of DPC is not impeded.

¹⁵⁵ Eskew, "In Defense of Direct Primary Care."

Conclusion

The physician-patient relationship is the indisputable foundation on which medicine rests. Put simply, a strong and healthy relationship with one's physician improves health along all fronts. Therefore, it is imperative that this fundamental relationship not only be protected but allowed to thrive. What are the conditions required for this to happen? The literature points to four: Time together, continuity of care, patient satisfaction (as influenced by wait times, choice of physician, and value of care), and physician satisfaction (as influenced by physician autonomy and administrative burden).

By and large, these factors are determined by a country's payment system, otherwise known as the way a country finances its healthcare. For example, single-payer drastically reduces administrative costs but increases the number of patients doctors are responsible for, both of which have a tangible impact on time spent together in the exam room. Meanwhile, within the United States' current multi-payer system, initiatives such as managed care, provider networks, electronic health records, and the Affordable Care Act have all had a harmful effect on different aspects of the physician-patient relationship. With this context established, this paper turned its attention to its true focus: Consumer-directed healthcare.

Looking at its two most popular forms, consumer-directed health plans (CDHPs) and direct primary care (DPC), the data was mixed. While individual healthcare spending did go down for CDHP enrollees, research seems to indicate that this was not the result of increased price shopping, the concept on which CDHPs are based. Furthermore, other measures of patient satisfaction were lower for CDHP enrollees as well, and the high out-of-pocket costs associated with the plans could lead to patients avoiding or delaying care, affecting both time spent together and

continuity of care. The success of direct primary care, on the other hand, tells a different story. Reports show that DPC patients have also experienced lower overall healthcare costs as well as increased interaction with their physician; furthermore, DPC providers have enjoyed high levels of professional satisfaction, leading many non-DPC doctors to consider entering the model. However, significant concerns do exist regarding potential access issues for low-income individuals and families.

Healthcare reform is controversial because each potential solution comes with a distinct set of pros and cons, and consumer-directed healthcare is no different. While extensive further research is needed to conclusively determine its effects, two things seem to be true based on this paper's synthesized findings: 1) CDHPs have yet to produce evidence that widespread enrollment strengthens the physician-patient relationship, and 2) Patients and physicians alike stand to benefit from continued expansion of direct primary care.

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